DOCUMENT RESUME

ED 299 482 CG 021 127

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TITLE A Season of Loss: Training Manual for the Prevention of Elderly Depression and Suicide.
INSTITUTION Suicide Prevention Center, Inc., Dayton, OH.
SPONS AGENCY Miami Valley Area Health Education Center, Inc., Dayton, OH.; Wright State Univ., Dayton, OH. School of Medicine.
PUB DATE 88
NOTE 60p.
AVAILABLE FROM Suicide Prevention Center, Inc., P.O. Box 1393, Dayton, OH 45401-1393 (manual and video).
PUB TYPE Guides - General (050)

EDRS PRICE MF01/PC03 Plus Postage.
DESCRIPTORS Counseling Techniques; *Crisis Intervention; *Depression (Psychology); *Instructional Materials; *Older Adults; *Prevention; *Suicide; Theories

ABSTRACT

This instructional module emphasizes that depression and suicide are real problems for elderly people, shows how depression and suicidal thoughts can arise in older people, and describes interventions that can be used. Chapter 1 presents an introduction and overview of elderly suicide and includes sections on the plight of the elderly, community attitudes toward elderly depression and suicide, life and suicide in a nursing home, statistics on suicide, cohort effects, and elderly suicide in the future. Chapter 2 looks at the prevalence of elderly depression; definitions and etiologies of depression; theories of depression; learned helplessness; endogenous and exogenous depression; neurotic and psychotic depression; difficulties in diagnosis; senility; medication; alcohol; and depression in nursing homes. The third chapter presents interventions in elderly depression, including the development of a therapeutic relationship; psychotherapy; and cognitive behavior, supportive, behavior, family systems, group, and drug therapies. The fourth chapter examines and defines elderly suicide; presents models and theories of suicide; and considers issues of assessment of suicide risk and lethality. Chapter 5 presents interventions in elderly suicide and includes an example of a suicide program. Chapter 6 considers ethical and legal issues such as competency, the rights of the family, types of guardianship, and informed consent. Relevant materials are appended. (NB)

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A SEASON OF LOSS

Training Manual for the Prevention of Elderly Depression and Suicide

Funded by

Wright State University School of Medicine
AHEC Program

and

Miami Valley Area Health Education Center, Inc.

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Preface

Although teenage suicide has received considerable attention in the media, elderly suicide is a bigger problem in our country. In the U.S., as in other western countries, the overall suicide rate increases with age. Over five recent years, the suicide rate for people between the ages of 65 and 74 was 45% higher than the rate for 15 to 24 year olds, and 85% higher for people 75 and over (National Center for Health Statistics, 1979-84). In 1980, people 65 and over accounted for approximately 4,800 suicide deaths. Why are more people not concerned?

Osgood (1985a) attributes the apathy about elderly suicide to cultural attitudes. We tend to accept suicide more with older people because they have lived richer, fuller lives. Suicide may be more "OK" for an older person if they have an incurable, chronic illness. It may also be that dying is seen as something old people are supposed to do, so suicide fits better with an older person.

For older people in nursing homes, the outlook is both better and worse than for the elderly living in the broader community. On the positive side, professional care providers can observe their patients. Depressed residents may be more likely to get help for their depression, and there may be fewer opportunities for suicide. It is conceivable that people in nursing homes also have more chances to interact with other people, which may improve their outlook.

People in nursing homes, however, often face immense losses of home, health, and friends, which may result in depression and suicide. Moreover, nursing home staff often have little exposure to depression and suicide, so that when suicide does occur it may not be handled as well as it might be.

This instructional module is designed to emphasize that depression and suicide are real problems for elderly people whether they are in institutions or not. It shows how depression and suicidal thoughts can arise in older people, and some of the interventions that can be used. The program includes a short section on ethical and legal issues, and encouragement for institutions to develop policies regarding depression and suicide.

The module includes:

1. An instructional manual which contains information for addressing special issues;
2. Handouts which can be duplicated for staff;
3. A listing of area resources;
4. A 26 minute Videotape in 1/2" HS format; and
5. Three lesson plan outlines focusing on different issues which are intended for different levels of instruction.

Additional copies of the manual and video may be arranged by contacting:

Suicide Prevention Center, Inc.
P.O. Box 1393
Dayton, OH 45401-1393
Phone (513) 223-9096

A feedback instrument is included in the back of the manual. Please let us know how we can improve this program.

The video tape was produced by the TV Center at Wright State University, Dayton, Ohio 45435. The entire project was funded by a grant from Wright State University School of Medicine and the Area Health Education Center, Inc.

Special thanks to the residents and staff of Englewood Manor and Greenwood Manor who generously donated their time and home to this project. And to Rita Enigk and Helen Wyskiver for their help with all of the drafts of this manuscript.

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Overview of Elderly Suicide

Statistics on Elderly Suicide

Elderly people are more likely to kill themselves than those in any other age group. In the U.S. population as a whole, there is a roughly linear relationship between suicide rate and age from adolescence into old age. As seen in Figure 1, the mean suicide rate for the period from 1979 to 1984 increased from 12.18 to 21.42 per hundred thousand going from the 15-24 to 85+ age groups. This reflects an increase of 79%.

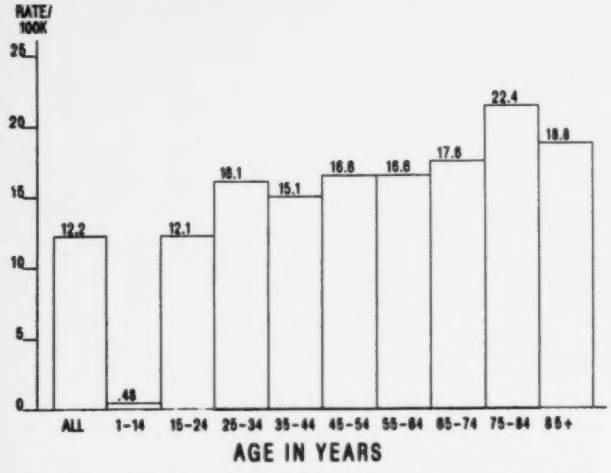


Figure 1. Mean Suicide Rate in Age Groups, 1979-1984 adapted from The National Center for Health Statistics, 1979-1984.

This higher rate of elderly suicide has persisted over time. As seen in Figure 2, from 1960 until 1984 the suicide rate for people 65 and over was an average of 82% higher than that of the general population.

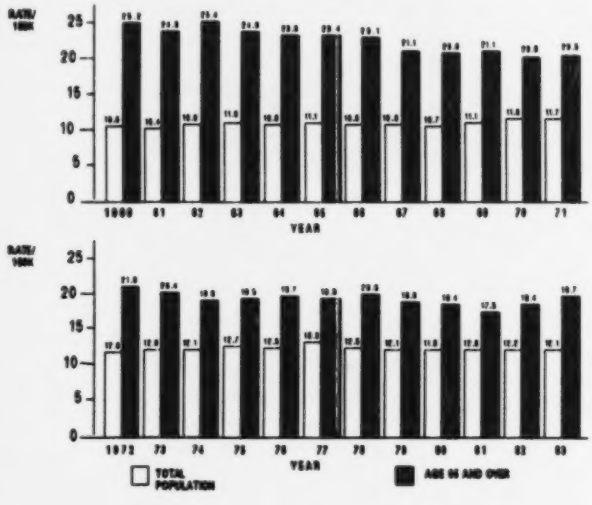


Figure 2. Suicide Rates per Year, 1960-1984 adapted from The National Center for Health Statistics, 1960-1984

These rates reflect a large number of people. The National Center for Health Statistics (1980) indicated that people 65 and over were responsible for 17% of the 28,290 completed suicides that year—about 4,800 deaths. Since the U.S. Census for 1980 indicated that only 10.7% of our population fell in this category, it is also clear that elderly people are losing more than their share to suicide.

Also apparent from Figure 2 is that while the suicide rate for the overall population increased slightly during this period, the elderly rate declined until 1981 (from 25.63 to 17.5 per hundred thousand) and then increased to 19.67 per hundred thousand by 1983. Busse (1974) attributed this decline to the use of antidepressant medications, effects of suicide prevention centers and mental health programs, and increased economic security resulting from Medicare and Social Security programs.

More recently, Haas and Hendin (1983) have shown that cohort effects have contributed to the decline in the elderly suicide rate. A cohort is a group of people who were all born in the same year. Since our culture changes, different cohorts grow up in times when different attitudes and values are prevalent. Different cohorts also experience different events in history, or they can experience them in different ways. In comparing different age groups it is important to take the effects of cohorts into consideration, because otherwise it is impossible to tell whether one is seeing an age-dependent phenomenon or not. The current generation of elderly people has had a lower rate of suicide through all their life than the cohorts which preceded them, and Blazer (1986) has shown that these effects continue at least until the age of 75. Finally, McIntosh (1984) has also shown that the recent relative increases in the proportion of the elderly who are female or belong to minority groups have helped to lower the elderly suicide rate.

When suicide statistics are broken down into components of sex and race, it becomes apparent that the age-related increase in suicide rate is primarily a white male phenomenon. McIntosh and Santos (1985) found that differences in suicide rates between sexes were greatest among the elderly. As shown in Figure 3, the rate for white females (averaged over the period from 1979 to 1983) peaked in the 45-54 year age group and then declined into old age. The white male rate over all ages was about three times as high as the female rate. For the 75-84 year age group, it was eight times as high and for the 85 and over group it was eleven times as high. The rates for non-white people of both sexes peaked in early adulthood at 12.2 per hundred thousand and leveled off at around 7 per hundred thousand thereafter.

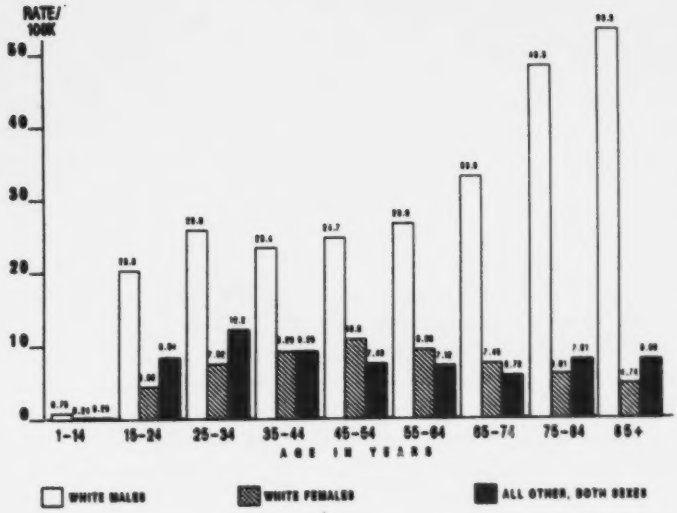


Figure 3. Suicide Rate of Age Group for white male, white female, and non-white populations adapted from The National Center for Health Statistics, 1960-1984.

Suicide in Nursing Homes

There is little information available about suicidal behavior in nursing homes. In a preliminary report of a study in progress, Osgood and Brandt (1987) have found that the prevalence of suicide in long-term care facilities is comparable to that in the general population. They studied both overt suicide and intentional life threatening behavior (ILTB). ILTB includes one or more repetitive acts by individuals directed toward themselves which result in physical harm or tissue damage, and which could bring about the premature end of life. Examples would include refusing medications or having serious "accidents". Osgood and Brandt (1987) sent questionnaires to a random sample of 1080 administrators of long term care institutions. Of the 463 responding administrators, 84 reported at least one instance of suicidal behavior (overt or ILTB) in 1984 and 1985. Seven reported five or more instances, and many reported between one and four instances of suicidal behavior. The overt completed suicide rate for the total institutionalized sample was 15.8, as compared with 19.2 per hundred thousand for the community elderly in 1983. Because this rate is based on a small sample size, caution is needed in interpreting the results. Osgood and Brandt attributed the somewhat lower completion rate within institutions to several possible factors. Suicides in nursing homes might not be accurately recorded and reported because they might reflect poorly on the reputation of the institution. It is also possible that greater supervision in nursing homes might decrease the rate. A final factor that would explain the lower nursing home rate is that deaths from intentional life threatening behavior might be included as suicides in the community statistics. The institutionalized sample rate of death from ILTB was 79.1 per hundred thousand.

Osgood and Brandt (1987) also report suicide rates by gender and race which are comparable to community rates. White people in institutions had higher rates than non-whites, and males had higher rates than females.

Osgood and Brandt's (1987) most important finding is that elderly suicidal risk within institutions is greatest among the old old, whose health is frailest and who typically engage in ILTB because overt means of suicide are unavailable to them. The two main methods of suicidal behavior in this age group were refusing to eat and refusing medications.

Elderly Suicide in the Future

There will probably be an increase in the number of elderly suicides in the future simply because the size of the elderly population is expected to increase. The current trend of decreasing aid to the elderly through reductions in social welfare programs may also influence the elderly suicide rate. Blazer (1986) notes that the current cohort of elderly people has had low rates of clinical depression and suicide, but that rates for subsequent cohorts (the baby boomers) have been higher. All of these factors may operate to raise the elderly suicide rate in the future.

Elderly Depression

Prevalence of Depression in the Elderly

Most authorities consider depression to be the most common psychological disorder of old age. Epstein (1976) has noted that depression has historically been thought to occur along with the aging process. Estimates of the prevalence of depression among the elderly vary widely for several reasons. The symptoms manifested by older depressed people vary more than those of younger ones, and symptoms of depression in old age are often confused with other physical or mental conditions. Moreover, different means are used to assess depression by different workers, and there is disagreement as to what exactly constitutes a depression. Rates as high as 50% and 65% have been reported (Rosenfeld, 1978; Epstein, 1976). However, Blazer (1982) notes that when clinical psychiatric evaluations are used, the prevalence of major and minor depression in the elderly population is only between 2 and 5%. Fry (1986) reports that prevalence studies indicate that 15% to 20% of elderly persons living in the community show significant symptoms of depression, and that as many as 25% of elderly persons in institutional care settings experience depression.

A Definition of Depression

D ression includes many things, but it is usually defined in terms of mood. The current *Diagnostic and Statistical Manual* (DSM III-R, 1987) describes it as a dysphoric mood or loss of pleasure in all or almost all usual activities. As such, the mood of depression can range from disquiet and restlessness to despair, emptiness, and numbness. A diagnosis of a major episode of depression requires that at least five of the following symptoms be regularly present for at least two weeks:

1. Depressed mood most of the day and nearly every day.
2. Poor appetite or weight loss, or increased appetite or weight gain.
3. Sleep difficulty (insomnia) or sleeping too much (hypersomnia).
4. Psychomotor agitation or retardation (but not merely subjective feelings of restlessness or being slowed down).
5. Loss of energy, fatigability, or tiredness.
6. Loss of interest or pleasure in usual activities, or decrease in sexual drive not limited to a period of delusion or hallucinating.
7. Feelings of worthlessness, self-reproach, or excessive or inappropriate guilt.
8. Complaints or evidence of diminished ability to think or concentrate (such as slowed thinking or indecisiveness).
9. Recurrent thoughts of death or suicide, or any suicidal behavior.

Bipolar disorder is another type of affective disorder distinguished by the DSM III. Bipolar disorders have both depressive and manic phases. Mania is characterized by an elevated, expansive, or irritable mood. Associated symptoms described by the DSM III include pressure of speech, flight of ideas, hyperactivity, inflated self-esteem, distractability, decreased need for sleep, and excessive involvement in activities which have an unrecognized potential for painful consequences.

Zung (1980) noted that bipolar disorders typically have an earlier onset in life than major depressions (around 30 as compared to 45 years) and that genetic factors play a large role in bipolar disorders. According to Blazer (1982) it is unusual to encounter manic episodes late in life. When they are seen, overactivity is not as pronounced as with young people, and manic symptoms may be intermixed with depressive ones, which makes diagnosis more difficult. Obsessive thought patterns may be seen in place of the flight of ideas of younger manics, and paranoid delusions are much more likely. Kaszniak and Allender (1985) suggest that the decreased need for sleep in elderly patients must be evaluated in comparison with their recent history rather than their life-long pattern. Blazer (1982) observed that people with major depressions are more agitated during depressive episodes and are more likely to experience insomnia than individuals with bipolar disorders, who tend to exhibit more lethargy and hypersomnia. Fry (1986) noted that bipolar patients have higher rates of alcoholism and suicide than patients with major depressions.

Dysthymic and Cyclothymic Disorders are chronic affective disorders whose symptoms persist for at least two years but which are not severe enough to warrant a diagnosis of a major depression or bipolar disorder. Periods of normal mood lasting up to a month are possible with both of these disorders.

Depression and Sadness

It is useful to distinguish depression from sadness, which is a normal feeling that usually results from a loss of some type. Old age is characterized by losses, and this period is sometimes called "a season of loss." Older people lose friends to death, their jobs and income to retirement, their neighborhoods through moving to nursing homes, and their health through natural processes. Losses of status, identity, self-image, and self-esteem are associated with all of these losses. As a result, there are often substantial reasons for an older person to feel sad. In depression, however, sadness is profound and out of proportion to life events. Conversely, depressed people may not feel sadness or any other emotion. A lack of feeling is often a presenting symptom in depression.

Etiology of Depression

Both biological and psychological theories have been proposed to explain the development of depression. This is not surprising since depression is a disorder with both physical and mental aspects. While it is not possible at this time to ascribe causality to either realm, an understanding of these theories is important to understanding the distinctions that are made in types of depression.

Biological Theories of Depression

Biochemical theories suggest that depression is caused by low levels of neurotransmitters in the brain; particularly norepinephrine and serotonin (Schildkraut, 1965). These theories were based on the fact that two groups of antidepressant medications, the tricyclics and monoamine oxidase inhibitors, both increased norepinephrine and serotonin levels. However, these increases were found to last only for the first few days these medications were administered, after which they returned to previous levels. Since these medications require two weeks to become effective, a simple deficit of neurotransmitters is no longer considered a plausible model (Heninger, Charney & Menkes, 1983).

Genetic theories postulate that depression is inherited or that some people have an hereditary predisposition to become depressed when placed under stress (a diasthesis-stress model of depression). Family and twin studies have shown that with bipolar disorders especially there is an hereditable component to depression. Allen's (1976) review of the literature showed a 72% rate for bipolar disorder in identical twins and only 14% in fraternal ones. Another genetic model proposed by Blazer (1982) suggests there is a genetic component to brain cell loss in areas of the brain which regulate norepinephrine production.

Physical illness has been closely linked to depressive illness. According to Verwoerdt (1981) the depth of depression ensuing from illness is related to the severity and duration of physical illness. Ouslander (1982) notes that illness, especially when accompanied by pain and disability, leads to an alteration of routines, diminished self-esteem, increased fear and dependency; all of these lead to depression. Cardiovascular and nervous system disorders are the most threatening and disabling diseases commonly faced by elderly people.

Fry (1986) observed that depression may be concommitant with many diseases, and that in some cases the symptoms of depression may be mistakenly attributed to a physical disease. In the early stages of cardiovascular disease, for example, severe depression may occur and produce symptoms such as fatigue, exhaustion, and difficulty breathing which can be confused with cardiovascular symptoms. Among neurological disorders, Parkinson's disease has been associated with depression. Brown and Wilson (1972) report that between 40% and 90% of Parkinson's patients exhibit depressive symptoms. Diseases of the endocrine system are also linked with depression. According to Fry (1986) depressive symptoms are present in 80% of hyperthyroidism cases. Ouslander (1982) noted that any systemic disease with metabolic involvement can produce depression. He lists fever, dehydration, decreased cardiac output, electrolyte disturbances, and hypoxia as conditions which can precipitate depression.

Psychological and Psychosocial Theories of Depression

Melville and Blazer (1985) observed that most psychosocial theories of depression in late life involve an inability to cope with stress, particularly losses. This results from elderly people being more rigid and less able to adapt than younger people. Depression, in turn, is seen as an inability to maintain one's emotional equilibrium in the face of stress.

Grief is a major stressor in elderly people. The grief reaction itself is similar in its symptoms to depression, and must be discriminated through a patient's history. Grief results from losses of all types. Losing a pet, a home, a car, or a friendship may precipitate as great a reaction as losing a spouse. The patient's perceived loss is the key to the depth of grieving.

Zung (1980) suggests that because stress due to loss is common in the elderly, a certain amount of pessimism among older people is often considered the "normal neurosis" of aging. Extreme pessimism is not normal, even for older people. It is necessary for patient care personnel to be alert to disproportionately intense or prolonged grieving which may lead to depression and suicide.

Psychoanalytic View of Depression

Freud (1957) thought that depression resulted from grief work which was improperly done. Depression would require fixation in the oral stage, which produced dependency on some other person for self-esteem. When that person died, mourning work was never completed. Instead, the patient introjected or incorporated the lost loved one into her own personality and then directed any hate and anger toward the lost person inward against herself. Depression was a direct result of this self-hatred. Freud (1955) also related depression and suicidal behavior to self-punishment and to conflict between the life and death instincts. He believed that older people were unlikely to benefit from psychotherapy because they had lost the mental elasticity needed for change (1964).

Cognitive Theory of Depression

More modern psychological theories are cognitive in nature. Beck (1967) postulated that depressed people make logical errors in thinking when they evaluate themselves. In childhood, depressed people learn negative schemata (self-blame or a sense of failure) which guide them in interpreting events which happen to

them. Numerous logical errors may then be committed (Beck, Resnick & Lettieri, 1979). Depressed people may overgeneralize an insignificant failure such as forgetting to call someone into an overall conclusion of mental incompetence. They may magnify their losses and minimize their achievements, as when a husband remembers a spat with his wife and concludes they never do anything but fight. They can also arbitrarily infer negative conclusions based on nonexistent or insufficient evidence such as concluding that one is worthless because their wallet was stolen. Selective abstraction involves focusing on the negative aspects of a situation while ignoring positive ones, as when a patient ignores basically sound health and sees only a minor impairment. Another logical error is personalization. Here the patient personalizes some affront which was not personally intended, as when a patient decides someone is angry at them because they weren't greeted on entering a room. Finally, dichotomous thinking happens when a person sees events in absolute and opposite terms. A common example is when a person concludes they can not do anything right, or that everything they have done recently has been a mistake.

Ellis (1970) noted several irrational thoughts that characterize the thinking of the elderly. These thoughts often result in negative self evaluations. One is a belief that the important part of their life was in the past, and that without people who are no longer around they can not handle life. Another is the belief that one's children should be the major source of support. This idea may have been more common more when they were young people, but the culture has changed in this respect and older people may have difficulty accepting the change. The belief that all depression is externally caused is defeatist because it places the person at the mercy of the environment and denies the real control they have over how to interpret things or derive pleasure from events. Additional irrational beliefs that elderly people often hold include the idea that elders should be treated with deference and respect and that everyone in their family should love them (which often does not happen).

Learned Helplessness

Seligman (1974, 1978) has proposed a learned helplessness theory of depression which postulates that people become depressed when they are placed in a stressful situation and believe that they have no ability to control what happens to them. A key point in this theory is that depressed people adopt a depressive attributional style, in which they attribute the causes of their failure to internal, global, and stable causes. For example, an elderly person who attributes a poor relationship to their being an uninteresting person is making a statement that they are the cause of the difficulty, that they are uninteresting on all counts, and that they are not likely to change. A person who places some of the blame on the other person in the relationship, or speaks about specific things which caused a conflict is much less likely to suffer diminished self-esteem as a result of their attributions.

Other classifications of Depression

Endogenous and Exogenous Depression

A distinction is often drawn between endogenous and exogenous (reactive) depression. Lehman (1981) describes reactive depression as resulting primarily from environmental stress. As a result of the losses suffered in old age, elderly people are subject to more stress than other age groups and experience more events that may precipitate depressions. In contrast, endogenous depressions result from internal, biological factors such as genetic constitution or metabolic processes. There is no particular event which is thought to precede or cause endogenous depression. Zung (1980) noted that patients with endogenous depressions are usually older and show more intense physiological symptoms than people with reactive depressions. These include sleep disturbance, psychomotor agitation or retardation, appetite loss, and weight loss. More intense psychological symptoms such as guilt, remorse, apathy, and self-pity are evident. Individuals with endogenous depressions are also more likely to waken early in the morning and experience depression as worse at this time. The converse of these symptoms describe people with exogenous depressions: an event precipitates the depression; individuals blame others rather than themselves; they experience depression as worse in the evening; and are unable to fall asleep easily.

Some authorities question the utility of the distinction between exogenous and endogenous depression. Kolb (1977) found that depressed patients showed a smooth distribution of physical and psychological problems, which suggests that the distinction is artificial. Further, Roth (1986) declared that in the elderly both endogenous and exogenous depressions are typically precipitated by life events, and that the distinction of reactive depression is not helpful with this age group. This debate within the profession indicates that elderly depressed people may not fall neatly into established diagnostic categories even though they are depressed.

Neurotic and Psychotic Depressions

The distinction between neurotic and psychotic depressions is related to the one between endogenous and exogenous depressions but it deals with magnitude rather than with origins. Neurotic depressions are minor and personal, while psychotic depressions are major ones that are commonly associated with some internal, endogenous origin. Neurotic depressions are more common than psychotic ones and seem to result from difficulties in adapting to the challenges of old age. Fry (1986) points out that in working with the elderly, these terms can be interchanged since there is little difference from the standpoint of clinical symptoms. Roth (1986) associated endogenous depressions with bipolar disorders in young adults, but notes that with elderly people manic phases are seldom seen. He described neurotic depressions as extreme manifestations of long-standing problems. For example, a person who has been a loner all his life may have even more difficulty with interper-

sonal relationships when he gets older because he may not have learned social skills, may not have as large a pool of potential friends, or may not be able to reach or spend time with them. Neurotic depressions are difficult to treat, but individuals who have been able to handle the difficulties of life when they were young have the best prospects of benefiting from therapy.

Difficulties in Diagnosing Elderly Depression

The problem of detecting depression in the elderly is compounded by what Roth (1986) calls the relative silence of psychiatric disorders in the elderly. The characteristics of depressive illness that elderly people display can be less distinct than those of younger people. For example, older people may be apathetic rather than despondent. They may feel a sense of hopelessness and helplessness about the future and yet not elaborate upon it. Unresponsiveness or noncommittal answers that come from a sense of not having anything worth saying can mask their true feelings and mislead evaluators. Elderly people are less likely to verbalize their feelings. It is therefore important to be alert to facial expressions, body language, activity levels, and general demeanors of the elderly.

Osgood (1985) also noted that depressed elderly people often complain of physical problems rather than psychological ones. These include complaints of changes in eating and sleeping patterns, fatigue, increased heart rate, headaches, muscle pains, and constipation.

Depression and Senility

Depression in the elderly is often confused with senility. In fact, pseudodementia is a term sometimes used to describe elderly depression because its symptoms can resemble those of an organic brain disorder. Personal neglect, a lack of verbal communication, a low affect, psychomotor retardation, apparent memory loss, and withdrawal from activities may seem like dementia (Fry, 1986). Dementia itself is also associated with depression in its early stages; some patients may be both senile and depressed. Since interaction with patients is unlikely if staff believe they are unable to respond and interaction is desperately needed by depressed people, it is important to discriminate depression from senility. This may require the systematic assessment of a psychological evaluation. People with dementia often struggle to get answers to questions on mental status exams "correct" and will divert the interviewer to avoid giving answers. In contrast, depressed people are more likely to display an uncaring attitude or simply cry rather than answer questions. Recall of recent events also separates the depressed from the senile; even a patient's concern about having forgotten important information indicates their recent memories are intact and they may simply be depressed (Whall, 1986).

Additional distinguishing criteria are listed by Duncan and Welles (1980). People suffering from dementia often have symptoms of long duration. Their attention and concentration are usually poor and their symptoms are often worse at night. They note that demented people also retain social skills and use calendars and notes to remain current, while depressed people do none of these things.

Medications and Elderly Depression

The medications used by elderly people may cause or exacerbate the symptoms of depression. They may also mask depressive symptoms. The probability of side effects in the elderly is enhanced because their responses to drugs change due to decreases in metabolism and systemic efficiency. Elderly people are also not as able to maintain biochemical homeostasis (Fry, 1986). Antihypertensives such as reserpine, sulfonamides, steroids, corticosteroids, tranquilizers, analgesics, narcotics, L-dopa, digitalis, cancer chemotherapeutic agents, and neuroleptics are among the drugs that cause depressive symptoms (Cunningham, 1984). A disproportionately large part of the elderly population uses psychotropic medications, and special care is needed with these drugs. Larson, Whanger, and Busse (1982) note that drug interactions may occur between antidepressants and even nonprescription drugs such as antihistamines or sleep medications.

Alcohol and Elderly Depression

Osgood (1987) reports that more than one third of all suicides in the United States are related to alcohol. Authorities differ over whether alcoholism causes depression or depression causes alcoholism, but the connection between the two is well established and is particularly strong among the elderly. Blazer (1982) found the association between alcoholism, depression, and suicide increased in elderly populations.

Schuckit and Miller (1976) found more than half of the elderly alcoholics they assessed had an onset of the disease after the age of 41. Since depression is so prevalent in older people, it is conceivable that many use alcohol as a means of escaping depression and become ensnared in a cycle of evading problems which only becomes worse through time. These individuals would be considered "late onset" alcoholics. Osgood (1987) describes the "early onset" alcoholics as developing a pattern of alcohol abuse early in life and having a history of social and psychological problems as a consequence of alcohol abuse. Presumably, the prognosis is better for late onset alcoholics who do not have this history to overcome.

Signs of alcoholism include: increased alcohol consumption; angry, hostile, or belligerent behavior; an odor of alcohol on the breath (particularly in the morning); a flushed face; trembling; blackout periods; hangovers; alcoholic cirrhosis, hepatitis, chronic gastritis; drinking despite medical advice not to drink; problems with family members or friends; an inability to conduct everyday tasks without drinking; and financial problems related to alcohol abuse.

Depression in Nursing Homes

Depression is common in nursing homes. According to Chaisson-Stewart (1985), most of the 1.2 million people living in nursing homes do not require intensive nursing care, but 50% to 75% have some kind of mental or intellectual impairment. Safford (1979) also indicates that more than half of the residents in most nursing homes have a significant mental disturbance. Fry (1986) claims that 25% of nursing home residents are depressed, and Blazer (1982) places this figure between 30% and 50%.

Blazer (1982) attributes these high prevalence statistics partly to the vulnerability of elderly people to depression. The losses of old age engender depression. Moreover, depression and illness are correlated since an illness or disability is a condition for entry into a nursing home. The high rates of depression and mental disturbance are also partly due to the shift from providing mental health care in centralized mental hospitals to community-based long term care facilities and nursing homes. In the last few decades the number of nursing homes has increased rapidly; currently there are more than 25,000 long term care facilities in the United States.

Summary of Signs of Elderly Depression

The depressed elderly has been characterized as being "anxious, preoccupied with physical symptoms, fatigued, withdrawn, retarded, apathetic, inert, disinterested in their surroundings, and lacking in drive" (Zung, 1980, p. 353). According to Osgood (1987) numerous studies indicate that apathy, withdrawal, and functional slowness are common depressive symptoms in the elderly.

The signs and symptoms of elderly depression that have been reviewed in this section are summarized here:

1. A sad, depressed mood marked by feelings of helplessness, hopelessness, despair, sorrow, guilt, or blaming others. Conversely, depressed older people may also be anxious, inert, or disinterested.
2. Bodily, physical complaints (hypochondriasis). Patient may not verbalize feelings.
3. Agitation or retardation of activity or thought.
4. Social withdrawal and isolation
5. Significant loss of appetite and weight, or increased appetite and weight gain.
6. Change in sleeping or eating patterns.
7. Extreme fatigue.
8. Confusion and inability to do simple tasks.

Intervening in Elderly Depression

Many types of treatment are available for depression. The approach to care depends on the needs and abilities of the particular client and the resources available at the institution. Ideally all those involved with the care of the patient will contribute to the assessment of the patient and formulation of the plan.

The first step in intervention in elderly depression may involve cultivating an attitude that depression is not an inevitable part of old age that resists all efforts at treatment. Otherwise, it is unlikely that much effort will be devoted to intervention. Given that caregivers can instill and enhance a sense of hope and well-being in patients, the two most important steps in intervention are recognizing the signs and symptoms of depression early and creating multidisciplinary care plans for patients which will prevent as well as alleviate depression.

Developing a Therapeutic Relationship

A key factor in establishing a care plan for a depressed person is the development of a genuine relationship. The depressed person should perceive the caregiver as interested, understanding, and sympathetic because this will help them to develop self esteem. It will also provide an atmosphere of trust which will enable the patient to risk sharing feelings which might be socially unacceptable. An awareness of the feelings associated with depression, particularly helplessness, powerlessness, hopelessness, anger, and hostility, will aid empathy and the communication of genuine concern (Hawranik & Kondratuk, 1986).

Psychotherapy for Depressed Elderly

Blazer (1982) has noted that there are no therapies for depression specifically meant for elderly people nor is there data available on which therapies work best with them. Chaisson-Stewart (1985) reported on the lack of research showing whether age affects the outcome of psychotherapy. At present the elderly utilize psychiatric services markedly less than other age groups in the population. This is surprising since many elderly people face acute problems associated with the losses of old age and exhibit depressive symptomatology 15% to 20% of the time (Fry, 1986).

There are several possible reasons for the lack of elderly people in therapy. Elderly people may avoid psychotherapy because they attach a great stigma to it or think they should solve their own problems. They may be unaware of services available, or be unable to afford them. Within the medical profession, biases against serving the elderly may also limit treatment (Blazer, 1982). Chaisson-Stewart (1985), for example, cited a study showing that physicians refer fewer elderly people for psychiatric treatment. This may be because they overlook depressive symptoms in the elderly or simply accept them as a normal consequence of aging. Blazer (1982) described studies showing that psychiatrists rate younger patients as more ideal patients with better prognoses. He also noted that since little formal training in geriatric psychiatry is available, clinicians may be more familiar and effective with younger populations.

All of this is unfortunate, since the little evidence that is available indicates that therapy may be of benefit for many elderly clients. Clinical trials evaluating the effectiveness of interpersonal psychotherapy with 85 elderly people (aged 60 to 85) with diagnoses of major depression showed a decrease in depressive symptomatology within two weeks of the onset of treatment. The main difference that researchers noted between elderly and younger adult patients was that medical problems in the elderly population prevented the use of psychotropic drugs (Rothblum, Sholomskas, Barry & Prusoff, 1982). In another study, Parsons (1986) used pre and post testing to evaluate the effectiveness of reminiscence therapy on a group of six elderly people (aged 65 and over) and found a statistically significant decrease in Geriatric Depression Scale scores.

Cognitive Behavior Therapy

Gallagher and Thompson (1983) showed that brief cognitive and behavioral therapies were effective in nonendogenous depressions in the elderly and were more effective than brief supportive approaches. Cognitive therapy has also been demonstrated to be better than antidepressant medication in the treatment of depression in middle-aged adults (Beck, Rush, Shaw & Emery, 1979; Chaisson, Beutler, Yost & Allender, 1984).

Beck (1967) attributed depression to the logical errors people make in evaluating themselves. Emotions are seen as a result of thought processes that follow a stimulus, rather than simply a reaction to an event. The meanings attached to a stimulus determine the quality of the emotion; an event associated with personal loss may evoke feelings of sadness and depression. Other things associated with depression, such as helplessness and dependency, are seen as consequences of the depression rather than the cause (Beck, 1974).

Cognitive therapy focuses on the thought processes which precede the emotional responses. It attempts to identify what habitual negative thought patterns are and correct them. It requires the active cooperation of the patient; both patient and clinician must trust each other and collaborate to achieve these goals:

1. Define specific problems.
2. Set priorities of which problems to attack first.
3. Select a problem that is quickly solvable to show problems can be solved.
4. Demonstrate the relationship between thinking and feeling by asking what the client was thinking prior to an apparent mood change.

5. Socialize client into the active, structured milieu of cognitive therapy.
6. Self-help homework strategies are stressed and homework is seen as more important than therapy time (Young and Beck, 1982).

Two major cognitive techniques are used in cognitive therapy. The client is first taught to spot "automatic thoughts" which come to consciousness. These may be negative messages such as "I can't do anything right" or "This never works for me." Imagery, role playing, and journaling of destructive thoughts are typical strategies for eliciting these thoughts. Secondly, the client is encouraged to work backward from these thoughts to identify the underlying assumptions that they are based on, which are often absolute, distorted, and unrealistic (Fry, 1986).

In an overall course of therapy, the client proceeds through three phases. In the monitoring phase, the clients are taught to view their depressive thoughts as cognitive distortions. In the cognitive training phase, clients are taught to break automatic patterns of negative thoughts with alternative thoughts. In the application phase, they are asked to imagine situations which could induce a depression and rehearse ways to avoid getting into one. Cognitive-behavioral therapy can also involve behavioral techniques which are focused at inducing behavioral change. This in turn can be used to effect cognitive change. For example, a shy person who can be induced to take meals in the cafeteria would have reason to reject a cognition that meeting people is unbearable (Fry, 1986).

Chaisson-Stewart (1985) contends that cognitive behavior therapy is well-suited to the elderly population because it is cost-effective. She notes that the present cohort of elderly value the self-help approach of cognitive therapy and view it more as a learning situation than a stigmatizing psychotherapy. The structure it affords prevents confusion about goals and time commitments. The time limitations of the therapy appeal to whoever funds it. The clear goals reduce client distress, reduce time wasted on extraneous topics, and allow a multidisciplinary approach to therapy since others involved in the care plan can help the client achieve the goals. Since this therapy is amenable to a group approach, more clients can be treated by fewer personnel. The principles and techniques of cognitive therapy can be taught to nonspecialized staff in provider agencies so that the cost of support can be reduced. And, as already related, the effectiveness of the therapy has been demonstrated (Chaisson-Stewart, 1985).

Supportive Therapy

Fry (1986) maintains that supportive therapy is the most innovative and effective means of treating the depressed elderly. The therapy hinges on a supportive interpersonal relationship between the therapist and client which brings about changes in behavior, feelings, cognitions, and attitudes. This therapy relies on the psychological and gerontological training of the therapist for the soundness of the decisions made in therapy. Typical techniques employed include advice, guidance, empathic listening, reassurance, permissive attitudes, catharsis, and the therapist assuming a protective role. Supportive therapy may be practical in nursing home situations because the effort is directed at immediate, practical concerns and ways to remedy the difficulties.

Supportive therapy is also based on the notion that old age can be viewed as a series of losses, each of which carries their own burden of grief. By encouraging the catharsis of feelings of grief and depression, supportive therapy seeks to alleviate the pain associated with the loss. It attempts to strengthen the adaptive capacity of the client by compensating for deficits that are present. Finally, supportive therapy has the goal of enrichment, or enabling people to realize the potential for growth and fulfillment that are consistent with the individual's desires (Fry, 1986).

Behavioral Therapy

Behavioral therapy is oriented to changing behaviors which are viewed as maladaptive. In both hospital and community settings behavior modification is often used to encourage independent activities in depressed elderly people (Blazer, 1982). Since the focus is on immediate behaviors, no time is spent on past events as with other therapies. This results in efficiency, as well as avoiding the glorification of past events by the elderly. The elderly respond better to the active, limited, structured role of a behavior therapist and the direct approach of behavior therapy. The stress-induced anxiety of old age is amenable to behavior therapy. Behavior therapy makes the elderly person the agent of change, and fosters a sense of dignity and self-efficacy. Behavior therapy also makes no use of diagnostic labels which may have negative connotations (Fry, 1986; Cautela & Mansfield, 1977).

A tenet of behavioral therapy is that depression is a pattern of learned responses. Significant people in the depressed person's life are assumed to have somehow rewarded destructive thoughts or behaviors. With repeated reinforcement these behaviors become habitual. To treat depression, however, it is unnecessary to gain insight into the process by which that person became depressed because selective reinforcement of desirable behaviors should be sufficient to correct any undesirable ones (Fry, 1986).

The process of behavior therapy can be described as a series of steps. In step 1, the client comes to understand the link between emotions and the activity. This may mean teaching the client to observe and record moods. The objective of this step is to identify behaviors that can be changed and find better ways to handle unchangeable ones. In step 2, the client learns the skills needed to perform new activities. Step 3 encompasses the praise and reinforcement needed to maintain the newly acquired behaviors. In step 4, the client begins to initiate these changes in behavior, and in step 5, the skills learned are generalized so they can be applied to other situations in life (Fry, 1986).

Family Systems Therapy

Family systems therapy views the family as a system. Many problems are amenable to this perspective, but Blazer (1982) notes it is most commonly employed in situations where an elder family member has placed great stress upon a family. First the family must be evaluated. The structure must be defined and the normal operation of the system determined through an analysis of the roles each family member holds and knowledge about how families work. Interactions within the family and family values are characterized, and support and tolerance are evaluated. If any crisis exists, the therapist has to determine how it has disrupted the family. The therapist can help to alleviate many family problems by explaining how the depressed family member reacts within the family and teaching them how to communicate clearly.

Within the context of family systems therapy, there are four intangible supports which are important for older people. Elderly people require a dependable social network which will assist them in extended times of crisis. They need social participation and interaction, where both the older person and the family communicate and understand what is going on with each other. Elderly people need a sense of belongingness within the family, and a sense of intimacy that enables emotions to be shared among family members (Blazer, 1982).

Several types of problems are commonly seen in families of the elderly. Conflict among elderly spouses can occur when dormant problems in a relationship are reactivated by retirement or other losses of old age. A depressed older person often becomes dependent on the spouse, who with old age may be less able to care for the depressed partner and more resistant to the changes which come with depression. At the same time, the depressed partner may become angry and hostile towards the spouse. Family therapy in this case is oriented towards helping the couple cope with the disabilities of the depressed partner and helping the depressed partner cope with emotions of despair, anger, self-pity, or resentment (Fry, 1986).

Another common problem involves conflicts between the elderly and their adult children. If the older person moves in with adult children because of illness or other changes in living situations occur, the family is placed under great stress. The older person will often attempt to control the children by making them feel guilty or responsible for their problems, and the children in turn have guilt and resentment to deal with. Family therapy in this situation may be directed at enabling the children to be assertive with their parents or connecting them with support groups centered about this issue (Fry, 1986).

Finally, roles and communication often pose problems for the families of depressed elderly people. The diminished capacities of older people often force a role reversal as adult children take over caring for them. Not only may an older person have difficulty relinquishing a role as head of the family, but adult children may have trouble seeing themselves as their parents' keepers. If the family lacks the needed resources of trust, empathy, and generosity then the communication necessary to clarify roles may not occur. Family therapy in this case may be oriented to building strengths needed for communication. The elderly themselves can be useful resources in this process, since they can often help to build trust by helping adult children cope with problems such as midlife crises (Fry, 1986).

Group Therapy

Group therapy offers a number of advantages over individual therapy for the treatment of depression. Busse and Pfeiffer (1977) identify the purpose of group therapy as resocialization and learning problem-solving skills. They point out that it is cost effective because six to ten persons can be treated at once. Group members can exchange learning among themselves, making it an effective teaching tool. They also benefit emotionally from belonging to a social group, and can use the social skills they learn or relearn within the group to form other relationships outside the group. Groups provide people with an opportunity for emotional catharsis through communicating feelings to other group members, and lets them express existential concerns such as the losses of bereavement, work, and home, or the issues of death and futility (Yalom, 1975).

Group therapy also provides support for group members in times of crisis and lets older people develop and maintain relationships when they move to other communities or lose significant people in their lives. In this way, the group provides a real balance for isolation and loneliness and helps to instill a sense of identity and self-esteem in the members (Osgood, 1985a).

A wide range of purposes and therapy modalities exist for groups. Ingersoll and Silverman (1978) distinguish *here and now* groups from *there and then* groups. *Here and now* groups focus on present problems and recent losses with the aim of helping members to acquire skills needed to adapt to changes and cope with the accompanying anxiety. *There and then* groups attempt to reorganize and interpret events in the past so that a sense of satisfaction about the past can be gained and harmful patterns of thinking and feeling can be changed.

Fry (1986) uses this paradigm to classify various groups. Within the *here and now* groups she places behavioral groups geared toward relaxation training, assertiveness training, and self-instructional training. Relaxation of deep muscles helps some people to cope with
insomnia, tension, and chronic pain. Assertiveness training can enable elderly people to ask for help in getting their needs met, express feelings and prevent depressions by countering put downs. Groups which increase relationship and communication skills are also *here and now* groups. They use reflective listening exercises, modeling, and role playing to teach social skills to patients. Other *here and now* groups include reality orientation groups for disoriented or mentally impaired

elderly; remotivation groups which help stimulate apathetic, uninterested patients to become involved in their surroundings, and socialization groups which are intended to enable members to develop social skills, self-esteem, and self-confidence (Fry, 1986).

Reminiscence groups are one kind of *there and then* group. Reminiscence therapy involves reflecting on past events in order to work through conflicts that were never resolved. Thus therapy helps to put the content of one's life into some acceptable perspective. Also, some groups which focus specifically on depression are *there and then* groups. Expressive therapy groups use reminiscence, role modeling, re-enactment and reliving of emotions to help group members understand their thoughts and feelings. Age-integrated life-crisis groups have the task of coping with developmental crises peculiar to different seasons of life. Group members range in age from 15 to 80. The opportunity for group members to help each other alleviates depression. Finally, cognitive therapy groups exist which use the principles of cognitive therapy within a group framework. Group members are taught cognitive procedures such as spotting and stopping automatic thoughts, and then challenge irrational beliefs or distorted thoughts which surface in the group (Fry, 1986).

Drug Therapy for Depressed Elderly

Drug therapy is often seen as an indispensable part of the multiple simultaneous treatments for depression which have been proven successful in controlling depression in elderly people. Drugs are commonly used in treating elderly people (Blazer, 1982). Ray, Federspiel, and Schafner (1980) found that phenothiazines were the most frequently prescribed class of drug in one nursing home and the second most commonly prescribed drug for outpatients.

Drug interventions can carry hazards of their own. Physiological changes in older people prolong the action of many drugs, increase the hazard from the accumulation of drugs in the body, and can result in hazardous drug interactions. Borson and Veith (1985) recommend lower starting doses and slower increments for older persons and suggest that drug regimens be simplified where possible, with a treatment plan including a minimum course of treatment combined with other non-drug therapies. The elderly may also experience increased sensitivity to certain drugs through changes in brain receptor sites (Vestal, 1982). Blazer (1982) says that unnecessary medications or medications which aren't proven effective with the patient should be withdrawn. In some cases their withdrawal will reverse depressive symptoms and in others it may clear up the presentation of symptoms so that prescription may be undertaken more readily.

When a drug is prescribed for depression, the feeling of being depressed may not be the symptom the drug corrects. Rather, it may act to reduce problems with sleeping or appetite, or correct agitation or retardation. During the course of treatment it is necessary to reevaluate the drug's effectiveness by noting whether the symptoms are being reversed. The extent to which the patient is following the drug regimen should also be determined, and blood plasma level studies can be used to verify that the drugs are present at safe therapeutic levels. New tests are available for tricyclics. Blood level determinations are especially important in lithium therapy, because toxic levels of the drug are so close to therapeutic levels (Blazer, 1982).

Anticholinergic effects are the most common side effects of drugs used to treat depression. Dryness of mucous membranes, constipation, urinary retention, tachycardia, and impotence are among these side effects. Among the more serious side effects are bundle branch blockages (a cardiac problem) and the central anticholinergic syndrome. Blazer (1982) asserts that recognizing this syndrome is critical because it can be reversed by using physostigmine. The symptoms of central anticholinergic syndrome are psychotic thoughts, confusion and agitation, flushing, and dryness of the skin.

The principle drugs used in treatment of depressive disorders include tricyclic antidepressants, monamine oxidase (MAO) inhibitors, lithium carbonate, sedatives, and stimulants.

Tricyclics are indicated for depressed or apathetic moods and they can be especially beneficial to patients with intermittent, chronic depressive symptoms which are not pervasive. Tricyclics act to facilitate synaptic transmission. Different tricyclics work on different aminergic systems, so that if one is not effective another may be. The choice of tricyclic is made on the basis of the different side effects of the drugs (Borson & Veith, 1985).

Monamine oxidase inhibitors block the enzyme which breaks down serotonin, dopamine, and norepinephrine. These may help depressed people of any age who are not responsive to tricyclics (Borson & Veith, 1985). However little evidence is available to support their effectiveness, and they are not the first drugs of choice because they can interact with other medications and some foods to produce a hypertensive crisis (Blazer, 1982).

Lithium is used mainly in treating the manic phases of bipolar depression (PDR, 1987). Borson and Veith (1985) note that patients with dementia who develop mania-like symptoms may benefit from lithium therapy. Aging decreases the range between therapeutic and toxic dosages of lithium. The PDR (1987) cautions that therapy should be discontinued and a physician contacted if diarrhea, vomiting, tremor, drowsiness, or muscular weakness occur. Side effects include hyperthyroidism, cardiac dysfunction, and renal dysfunction but may involve any organ system. The 1987 PDR has two columns of warnings, precautions, and adverse reactions to lithium therapy.

In summary, a number of approaches are available for dealing with depression in the elderly. Psychotherapeutic approaches and psychopharmacological methods are currently in wide use for treating elderly depression.

Elderly Suicide

A Definition of Suicide

Shneidman (1963) points out that suicide is a mode of death indicated on a coroner's report; the options are natural cause, accident, homicide, and suicide. Suicide is an intentional death caused by one's self. Yet, this classification is vague because individuals may contribute to their own deaths in varying degrees and have varying degrees of intention. Suicide may be thought of as a spectrum of behavior, which ranges from culturally acceptable acts that may result in death (such as smoking or driving fast) to overt, unambiguous, life-ending acts (such as overdosing or jumping from buildings). Many intentional, self-destructive acts of elderly people such as failing to take proper care of themselves, refusing to eat, or refusing medications, are suicidal in nature. Since these acts do not result in immediate death, they are sometimes referred to as intentional life threatening behavior (ILTB).

There are several paradigms, models, or ways of looking at suicide which help to discriminate degrees of suicidal behavior and elucidate its various causes. Here they are presented as classifications and models. Classifications such as Menninger's (1938) classification or Durkheim's (1951) sociological paradigm distinguish different types of suicides, usually with the aim of showing differences in causality. Models such as the psychosocial or psychoanalytic view of suicide focus on the process of suicide rather than its structure. They, therefore, provide insight into how suicide may come about for a particular individual. Each type of model can give clues to suicidal risk and intervention.

Classifications of Suicide

Partial Suicides

Menninger (1938) used the term "partial suicides" to include self destructive behaviors which did not end in death. He distinguished three types of suicide. Chronic suicide is characterized by it's long-term nature. Alcoholism or antisocial behavior are examples of chronic suicide, which approaches a life style. Focal suicide is limited to a particular part of the body, as if killing part of one's self is a substitute for killing the whole self. Acts such as self-mutilation and accidents made to happen on purpose were included in this category, as was frigidity. Organic suicide resulted from mental processes associated with disease. Menninger saw self-punishing and hostile, aggressive behaviors as belonging to this category. Menninger's classification was an early one and it may have more utility within the context of psychoanalysis than in other settings. Generally, Menninger viewed suicide as arising from hatred, guilt, and hopelessness which expressed themselves as the wish to kill, to be killed, and to die.

Subintentioned Death

Shneidman (1963) used the term "subintentioned death" to refer to deaths in which the individual played some covert or unconscious role in either permitting or enabling death to occur. In one type of subintentioned death, an individual who lost the will to live might chance death by unconsciously engaging in behavior that could result in accidental death. A similar behavior especially applicable to older people who might not be able to engage in "dangerous" activities would be unconsciously hastening death by disregarding a medical regimen that could extend life. A third type of subintentioned death involves experimenting with death by using drugs to produce a continued state of escape or unawareness. A final, less common type of subintentional death involves capitulating to death. This happens when a strong emotion causes a person to play a role in their own death. Typical examples include "voodoo deaths", but in our society capitulation to death could happen if a person's fear of death were strong enough to prevent seeking medical attention, which in turn would bring about a death.

Both Menninger's and Shneidman's classifications of suicide expand our notion of what suicide is. When behaviors which do not immediately result in death and deaths which come about without conscious intentionality are considered the realm of suicidal behavior increases significantly. The awareness that many deaths and other self-destructive acts are within the individual's control provides a framework for viewing suicide as an individual's responsibility with the option of possibly preventing death from suicide.

Suicide Attempters and Suicide Completers

Maris (1981) takes a unique approach to understanding suicide by emphasizing the difference between explicitly self-destructive aggressive acts and relatively non-destructive behaviors. This difference culminates in a distinction between multiple suicide attempters and suicide completers who typically engage in only one lethal suicidal behavior. Although about 15% of suicide attempters eventually die by suicide, the great majority of them do not kill themselves. Instead, they are multiple suicide attempters who get attention from their family and temporarily escape responsibilities by attempting suicide and assuming a sick role. In contrast, 35% to 45% of suicide completers have made at least one prior non-fatal attempt (which means that 60% to 65% of completers die in the first attempt.) Elderly people, especially elderly white males, are typically suicide completers. It is uncommon for elderly people to cry out for help when they are suicidal. They are more likely to decide to kill themselves, make their preparations, and then complete the task. According to Maris (1981), four traits which characterize the lethal population are a history of chronic suicidality, the tendency to make only

one attempt, the use of highly lethal methods, and the structuring of the attempt so as to make a rescue unlikely.

A Sociological View of Suicide

Durkheim (1951) saw suicide as a consequence of unhappiness that resulted from an individual's lack of or improper involvement with society. He distinguished three basic types of suicide. *Egoistic suicide* resulted when a person was not intimately involved with others in formal and informal social groups. Isolated individuals would be unable to hear that other people cared or wanted them to live, and would be less likely to keep living when confronting the possibility of suicide. *Anomic suicide* occured when society failed to provide a clear role for the individual to fill, or when the roles and relationships a person had with society were suddenly ended. Many of the sudden changes of old age, such as retirement or the death of a spouse, can radically restructure an individual's roles in society. A third type of suicide, the *altruistic suicides*, describe those which are expected by society. This type of suicide may apply more to eskimo or primitive nomadic societies than our own, but this dynamic can still exist within some families (Durkheim, 1951).

Durkheim (1951) described most elderly suicides as being egoistic because elderly people relinquish roles and positions within society and are therefore less well integrated into it. They lose contacts with other people and have to rely upon only their own resources when facing the troubles of life. Of course, elderly people can also be at risk for anomic suicide if they are left to structure their own roles as old people.

Another view suggests that social isolation as a causative factor in suicide loses importance when seen in the context of a suicide completer's life history (Maris, 1981). The important factors are the ones which cause a person to become isolated, rather than the experience of isolation at the time of death. Suicide completers can be seen as having "suicidal careers" which reach back over the course of their lives, for example, negative early social interaction. The effects of isolation can depend upon the situation. People isolated with only a few individuals in small, unchanging environments tend to become irritable and aggressive. Those who are wholly isolated or are confined with others with no hope of removal become listless and hopeless. Maris (1981) speculated that the latter situation correlates with suicidal behavior, although depression can characterize both situations.

Psychosocial Models of Suicide

Models of suicide are useful in providing insight into why suicide happens and suggesting points at which intervention may occur. Most models of suicide in the elderly involve depression. Although hostility is often involved in the suicide of a young person it is rarely seen in elderly suicide (Tideiksaar, 1985). On the other hand, depression is endemic in the older population.

Many models of suicide also involve stress and coping, because these concepts are germane to the large number of interrelated factors that are involved in elderly suicide. Selye (1976) defined stress as any physical stimulus or emotional factor that places a strain on the homeostatic system. Coping means adapting to stress in order to maintain the equilibrium of the system. Elderly people face many sources of stress and most involve losses of some type.

Osgood (1987, personal communication) reports that in her ongoing, on-site study of nursing homes, the greatest stressors associated with suicidal behavior in the resident populations thus far are the fears and losses associated with moving into the institution, feelings of rejection and abandonment by family members (even in situations where family members make daily visits), and fears and losses accompanying a move within the institution (as when the cessation of medicare payments forces a move from one room to another).

There is evidence that these concerns differ from those of the general elderly population. In a study involving elderly in the community, George and Siegler (1982) surveyed stressors affecting 100 men and women aged 55 to 80 in North Carolina. Sixty percent of the stresses reported were of a personal nature and 40% were interpersonal. Among the personal sources of stress, 25% involved health, 15% involved self-concerns such as boredom or loneliness, and 12% were economic in nature. The largest source of interpersonal stress involved family interactions. Interestingly, as the age of the respondent increased, there was a dramatic increase in the number of personal events reported. This was interpreted in terms of Neugarten's (1973) narrowing social and psychological spheres that typify later life.

A Stress Model of Suicide

Osgood (1985a) proposed a stress model which is based on Selye's (1976) General Adaptation Syndrome. The General Adaptation Syndrome describes the three stages of reaction of an organism to stress: first an alarm reaction physiologically prepares the body for fight or flight; next a stage of resistance occurs wherein body defenses react to the stressor; and finally, exhaustion results when exposure to the stressor is prolonged beyond the body's level of endurance. With regard to this model of elderly suicide, the losses associated with aging produce stress. At first the individual rallies defenses and is able to cope, but prolonged stress combined with the blocking of routes of escape accelerate the effects of aging and gradually exhaust the individual. Coping mechanisms fail as the person's resources are depleted and the individual becomes more vulnerable to stress. Depression and despair set in. Suicide is seen as a response not only to these feelings, but to the situation and stresses that engendered them (Osgood, 1985).

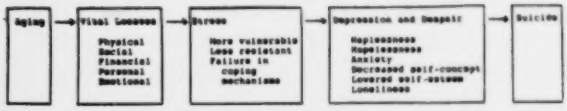


Figure 4. Osgood's Model of the Aging Process and Suicide

Osgood stresses that this is not an empirically based model, but indicates relationships which need to be researched in the study of elderly suicide. Its strengths are that it highlights the effects of losses that the elderly experience and affective changes that often accompany them.

Stages of Suicidal Thought Model

Another model which involves stress and an individual's inability to cope describes stages of suicidal thought (Suicide Prevention Center, 1986). A premise of this model is that there is a continuum of ambivalence between life and death. An individual at any point along this continuum weighs the advantages of each. Stress and the failure of coping mechanisms operate to make death more attractive and life less desirable, thereby shifting one's place in the continuum in the direction of death.

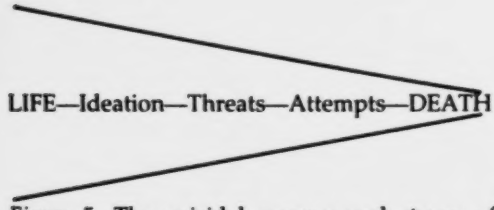


Figure 5. The suicidal process and stages of suicidal thought.

This model includes the process of dynamic constriction, shown by the converging lines toward the death end of the continuum. Constriction, also called "tunnel vision," operates to reduce the alternatives that people can see to ending their problems. They may be unable to conceive of common sense solutions to problems. They may be unable to remember means of coping they used in the past, and may find that even feelings are suddenly unavailable to them. As shown in the model, tunnel vision is more pronounced at the lethal end of the spectrum.

During the stage of ideation, ambivalence exists and life can seem overwhelming, but the life theme seems to be the strongest. Persons at this point can see some alternatives open to them and are willing to discuss and act upon life-oriented options. Suicide is seen as a distant option. This stage may last only a few hours, or it can be chronic, lasting for years.

In the threatening stage, the pain of the life situation increases and the attractiveness of death equals and begins to exceed the attractiveness of life. Individuals often perceive that no one has heard their needs or calls for help. A low level of coping is exhibited. Tunnel vision increases while the ability to discuss problems or act on life-oriented solutions decreases. This stage may last for days or weeks.

The death theme is strongest in a person on the attempting end of this continuum. Tunnel vision is greatest here. From the attempter's point of view, although life may still be desirable in some way, the pain involved with life is so strong that death is the only alternative. Attempters have probably considered many options before deciding on death, and are unable or unwilling to see alternative solutions to problems.

The Triangle Model of Suicide

A third model of suicide is called the triangle model (Cutter, 1983). In this model three forces move a person toward suicide: distress (which includes hopelessness and pain), a method of suicide, and the wish to die. All three forces must be present for suicide to occur. The wish to die is placed at the apex of the triangle because it requires both a method and distress to be expressed. Furthermore, the wish to die cannot be directly altered. Instead, the means of death must be made unavailable or the person's level of distress must be reduced to prevent the occurrence of a suicide.

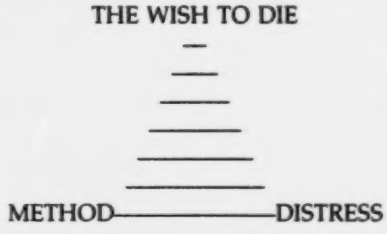


Figure 6. The Suicide Prevention Triangle described by Cutter (1983)

According to Cutter (1983), distress is the motivation for suicide and is manageable through crisis intervention, tender loving care, problem solving, constructive listening, and providing opportunities for catharsis. Even in a nursing home, this may be a more accessible means of address than removing the method of suicide, particularly when the method involves refusing to eat or take medications.

Developmental Models of Suicide

The Psychoanalytic Theory of Suicide

Some models of suicide work on the premise that an individual's path to suicide begins in childhood. People acquire a predisposition that makes suicide a more likely possibility for them than for other people. The psychoanalytic model is the most prominent example of this type. Freud viewed suicide as the result of mourning work which was improperly done (1957). When a loved person was removed through death, that person was introjected or incorporated into the mourner's person-

ality. Hatred toward this ambivalently viewed love object was then directed against one's self. Eventually the wish to die was also directed inward, and suicide resulted. Since this first model was limited in its applications, it was supplanted with one that relied on the interplay of life and death instincts within a fragmented personality structure to explain how an individual could perform such a desperate act (Freud, 1957).

Freud viewed personality as a three-tiered structure consisting of the id, ego, and superego. In this scheme, the id is a repository of the life and death instincts, Eros and Thanatos. The id operates on the pleasure principle, seeking immediate gratification of its desires. The ego develops out of the id in the second six months of life and operates as an interface between the id and the external world. The ego is the part of the personality that delays gratification, plans, and makes decisions needed to function in the real world. The superego represents the mores and precepts of the parents and society; it provides the ego with moral judgements of right and wrong.

When it is first formed the ego is weak and powerless, but as the infant grows the ego develops many important defensive functions such as an orientation to the external world and the ability to control dangerous thoughts and wishes. Freud thought that during times of extreme stress, people could regress to earlier ego states which did not have these protective functions and suicide would become a possibility (1957).

Suicide was especially likely when a person's ego was not well integrated to begin with. The ego, according to Litman and Tabachnick (1968), consists of a predominant action self and a group of subselves which have different values and biases than the action self. These subselves are formed through life experiences such as conflict or imitation of a loved, respected person. Suicidal subselves can be formed if a person identifies with some other important person who was suicidal. Another way for them to arise is if a person feels rejected or mistreated, and comes to think that the only way to receive love is through self-destructive acts.

Ordinarily, the action self is in control and it allows people to evaluate problems and make decisions rationally. However, if a crisis confronts a person whose ego fragments easily under stress, any suicidal subselves that are present may become dominant. Even if they only temporarily determine the person's actions, a suicide may result.

This easily fragmented ego and the presence of suicidal subselves can be interpreted as weaknesses or predisposing conditions that make suicide more likely (Litman & Tabachnick, 1968).

Another important aspect of the psychoanalytic theory of suicide is the presence of suicidal fantasies. These fantasies commonly have themes of escape and sleep, guilt and atonement, vengeance and punishment, masochistic surrender and reunion with departed loved ones, or rebirth and a new life. In the short term they may serve a useful purpose by providing people with temporary relief from stress. However, these suicide fantasies engender suicide plans which constitute a real danger to people. Litman and Tabachnick (1968) argue that impulsive suicide is an exceptional case. They say that planned suicides are typically much more lethal, and that the suicide plans are rehearsed in fantasy and evolve over a period of time. The plan itself is critical to the suicidal process because it is the means by which fantasy is translated into action. Moreover, the plans tend to take on a life of their own. Rehearsal strengthens them and they are reinforced by statements the person makes, such as "you won't have to worry about me anymore." The plans gradually become acceptable to people, and although they may be postponed they have their own momentum towards completion.

The Assessment of Suicidal Risk

Risk Factors

Suicidal risk is a subjective determination commonly assessed by considering the risk factors which apply to an individual, observing any clues or indications they may be giving of suicidal intent, and more formally by administering psychological tests or a mental status exam.It is impossible to precisely assess suicidal risk or predict the timing of suicide attempts. In all cases, indications and threats of suicide must be taken seriously. It is better to err on the side of caution in assessing risk.

The following risk factors have been clearly associated with suicide in elderly people. Suicidal risk increases with the number of factors that affect an individual, and with the depth of the individual's reaction to them.

1. *Race:* White, Chinese-American, Filipino-American
2. *Age:* Highest risk over 75
3. *Sex:* Male, especialy white males
4. *Marital Status:* Unmarried, especially bereaved
5. *Work Status:* Unemployed, retired
6. *Environment:* Socially isolated, especially from family and children; Low income urban areas; Risk higher with institutional admissions and discharges, and moves within an institution
7. *Religion:* Higher risk if no religious beliefs
   Risk higher for Protestants than Catholics or Jews.
8. *Health:* Active chronic illness; painful or terminal illness.
9. *Substance Abuse:* Especially alcoholism.
10. *Bereavement:* Especially death of spouse.

11. *Psychological Syndromes: Depression* (2/3 of elderly attempters are depressed); *Tension and Agitation;* Guilt *and Dependency;* and *Anxiety Disorders*

12. *Economic Difficulties*

13. *Previous Suicide Attempt:* Loss of loved one to suicide

14. *General Interpersonal Problems:* Including sexual problems. (Tideiksaar, 1985; Osgood, 1985a; Osgood, 1987; and Maris 1981).

Clues to Suicide

In 1971 Lester and Lester classified clues to suicide as being verbal, behavioral, and situational. Many of the situational clues have been listed under "risk factors," but other circumstances may indicate a suicidal crisis. Any major change in a person's life may precipitate a crisis whether it is a good change or bad one. Even changes which are seemingly insignificant such as moving to a different room or being assigned a different doctor may seem like major changes to the individual and can precipitate a crisis. This is particularly true when a person is depressed or has an anxiety disorder. In all cases it is important to ask patients about their own internal perception of events. Since some situational clues are not obvious, an individual's words and actions sometimes provide the first clue that something is wrong. Verbal clues to suicide include direct statements such as "I want to die" or "I'm going to kill myself." Statements such as these are a clear indication that a person is suicidal; they must be taken seriously.

More often people will make indirect statements about death because they believe that expressions of suicidal intent are socially unacceptable or because they want to find out whether a particular individual will be open and receptive to discussing suicide. A person may hint at death or joke about it, saying such things as "I'm tired of how things are going", "My wife would be better off without me", or "I'm not sure what's worse: death or taxes." Sometimes statements may be so oblique in their approach that they pass by undetected. Looking at all a person says and communicating unusual remarks to other staff members will enhance early awareness of suicidal thoughts (Shneidman, 1970).

Like verbal clues, behavioral clues may also be direct or indirect. A suicide attempt is a direct behavioral clue. Attempts must be taken seriously even if the method used seems unlikely to be effective. Repeated attempts are usually of a higher lethality (Slaikeu, 1984). Indirect behavioral clues often involve preparing to kill oneself and preparing for death itself. Acquiring a weapon or hoarding medications are clearly suspicious. Clues which involve preparing for death, by making a will, making funeral plans, putting personal affairs in order, or giving away possessions may be more difficult to detect in the elderly. Older people are expected to be preparing for death, so these clues may be ignored. Other clues listed by Osgood (1985a) include any uncharacteristic behavior such as going out at odd times of the day, sudden agitated behaviors such as fights with family members, a sudden interest or disinterest in religion, scheduling doctor's appointments without apparent cause, and a loss of physical or mental skills.

Formal Evaluation For Suicide

Since testing is often done after some problem is suspected, test results are more diagnostic aids than clues to suicide. They help to determine how depressed or how anxious a person may feel compared to others. A wide variety of tests to measure well-being are available (see chapter on Elderly Depression). In addition to these, psychiatric centers develop clinical histories of patients using the technique of reminiscence (anamnesis) and administer mental state exams to evaluate patients. Maltsberger (1986) provides typical examples of these instruments in his book by including the examination outlines used at Massachusetts General Hospital. They provide a useful range of topics to explore with patients.

The clinical history enables an accurate and fairly complete picture of the patient to be constructed. It includes sections on demographic characteristics of the patient; a statement of how the patient sees the problem; histories of the present and any past psychological illnesses; a family history which includes questions on relationships with parents, siblings, etc. A complete developmental history investigates the prenatal, infancy, toddler, pre-school, elementary school, and adolescent phases of life, as well as the adult occupational, military, sexual, marital, and medical history. An important point of the clinical history is that the patient's family members are also sought for their to contribution to the history, since the patient's recollections may be distorted. Topics in the clinical history instrument which focus on suicide include:

- -Previous suicide attempts
- -Suicidal behavior among family members
- -A history of child abuse, seduction, humiliation, rejection, or cruelty
- -Whether other important people are invested in the patient's survival
- -Whether anyone seems indifferent or wants the patient dead
- -Whether the mother could comfort the patient in infancy; whether mother and child were separated; surgery in the first two years of life; adoption or foster homes
- -Unusual struggles for control over the patient's body as a toddler
- -Whether the patient was accident prone in elementary school
- -Whether despair marked adolescence
- -Responses the patient has shown to unusual stress or loss

-Dependence on the spouse for self-esteem or emotional tranquility
-Use of sexual contact to enhance self-esteem
-Presence of suicidal daydreams
-How patient behaves when upset
-Whether patient panics or despairs when left alone

The mental state exam is a technical tool which provides the information needed to diagnose the patient's mental state in clinical terms. It requires the examiner to describe the patient's general appearance and behavior so that another could picture him. Detailed questions are asked about posture, facial expressions, motor activity, clothing, and details such as nail biting. The form and quality of the patient's verbal expressions are noted such as, amplitude, rate, spontaneity, and tone. Mood, mental content, disorders of thinking, intellectual functions, memory, fund of information, retention and recall, calculation, capacity for abstraction, grasp, and judgement are rated subjectively or using tasks included in the instrument. Topics on the mental state exam which focus on suicide include:

-Whether the patient has needle marks
-Whether the patient looks tormented
-Whether the patient seems to listen to unseen others
-Wringing of the hands, agitated behavior, pacing, striking self
-Presence of despairing mood, suicidal impulses, desire to attack someone, feeling of dying, feeling of aloneness, or self hatred.
-Presence of hope for the future
-Evidence of self-devaluation
-Whether he loves anyone
-Whether he values his work or anything else about himself
-Presence of voices commanding self-destruction
-Whether patient experiences self as physically empty, hollow, or unreal

Assessment of Lethality

The presence of risk factors affects the likelihood of suicidal thought and the degree to which death is desired. This in turn bears on lethality, which is the likelihood that a person actually will complete suicide. The assessment of lethality presupposes the existence of a suicide plan. According to Osgood (1985a) the existence of a plan is best determined by asking straight forward questions, such as whether the person is thinking of suicide or feels that death would be better than the present life. Rapport is required to broach these personal issues, and a friendly, normal tone should be used in speaking about them. If the patient denies suicidal intent, it indicates a low lethality potential. When clients admit they are planning to kill themselves, respond with self-accusations (such as "I don't deserve to live"), or balk at discussing answering questions about suicide, this indicates a high lethality potential.

Given that a suicide plan exists, the method can be rated for lethality. Violent methods such as firearms, knives, or jumping are more lethal than overdoses of pills. The likelihood of a rescue that a plan affords reduces its lethality. The selection of a date and time for the act increases lethality. Isolation from other people also increases lethality.

Intervention in Elderly Suicide

The Treatment of Suicidal People

Interventions used with suicidal people depend on their needs, capacities, suicidal risk, and the resources available. As a rule, it is better to be too cautious than neglect treatment. When in doubt, people should be assessed at their maximum level of suicide risk. Lethal patients should be hospitalized (Wekstein, 1979). Antidepressant medications, a suicide watch involving close supervision by nursing staff or a family member, and the removal of the means of suicide are other possible interventions.

Fry (1986) recommends one-to-one counseling for severely depressed patients. If the risk is not immediate, supportive counseling can be used to increase self-esteem and life-review therapy can help patients reconcile themselves to their pasts so they can view life differently. Measures should also be taken to reduce the stress in the patient's environment and provide for sources of contact and gratification.

If the lethality is judged to be low, the caregiver can assist by helping the patient to explore the problem, offering emotional support, and suggesting other sources of help (Slaikeu, 1984).

High Lethality and The Question of Hospitalization

Immediate action should be taken to protect an individual who has chosen a highly lethal means of suicide and has been assessed as a high suicide risk. Wekstein (1979) notes that numerous studies agree that anyone who has attempted suicide should be quickly hospitalized. Although there may not be enough beds to hospitalize all attempters and attempters could come to identify with a sick, dependent role (Kirstein, Prusoff, Weissman and Dressler, 1975), hospitalization still provides the best means of immediately controlling suicidal behavior and encourages follow-up on an outpatient basis.

When to hospitalize can be an agonizing question. Several sets of hospitalization criteria for suicidal patients have been proposed:

Kirstein, Prusoff, Weissman and Dressler (1975) developed the following criteria for hospitalizing an individual who is contemplating suicide:

1. A well-defined plan for self-destruction.
2. A recent history of medically serious attempts.
3. Suicidal gestures or ideations that represent psychotic thinking.
4. Suicidal ideation that has evolved into gestures.
5. A firm and rigid anticipation of hospitalization.
6. Social isolation.
7. Evidence of a well-defined suicide attempt.
8. Repeated verbalizations about suicidal wishes without seeing other alternatives.
9. Disappointment with inability to achieve gains from suicide attempts and inability to change behavior.

Comstock (1977) suggested that the criteria for hospitalization be based on the following:

1. Inability to respond to crisis intervention and still intend to kill themselves.
2. Hallucinatory or delusional suicidal states.
3. Moderate or severe depression exhibiting self-rage, self-blame, or self-punishing thinking.
4. Inability to form a therapeutic alliance with others because of an inability to interact.

Cserr (1978), the medical director of a psychiatric hospital, suggested that hospitalization be considered when:

1. The origin of the suicidal impulse is not understood in the context of the patient's illness.
2. The patient is likely to attempt suicide to manipulate others or through regression.
3. Any other disorganization could lead to destructive acting out.

A Suicide Watch

Often a suicide watch is instituted following a suicide attempt. Kalkman (1982) described several precautions which are indicated. In a facility without a psychiatric unit, the patient should be placed in a private room and a special duty nurse should be assigned to supervise the acutely suicidal patient at all times. Windows pose a special problem. If possible, they should be made of safety glass or fitted with screens to restrain patients from jumping. An alternative to this is selecting a room with only one window and having the nurse take up a position between the patient and the window. Any materials which could be used to complete suicide such as drapery cords or appliances should be removed from the room. Medicines, thermometers, and rubbing lotions should be kept in a locked bathroom. Beyond this, it is important to remember that suicidal people can be very creative and despite the best precautions they may still be able to think of a way to kill themselves using whatever they can find. Because of this, the nurse should not leave the room. Materials which are not in the room (such as linens or food trays) should be brought to the nurse (Kalkman, 1982).

The relationship which develops between the nurse and the patient can be a major factor in preventing further attempts while the patient is on the ward. In many respects such a relationship is preferable to the use of dehumanizing physical measures to prevent a suicide. While removing even shoelaces from a patient may be effective in the short term, it may impair a person's chances for future recovery. Kalkman (1982) claims that suicidal patients sometimes remark that they won't complete suicide while a nurse they have become attached to is on duty, or while they are in a hospital that they have developed loyalties to. The patient also benefits

from a sense of control that results from being able to use caregivers for support.

Suicide and Crisis Intervention

Older people can face suicidal crises, particularly when they lose a spouse or something else of great importance to them. A crisis here is defined as a period of intense emotional upset which results from some external cause. Feelings of being overwhelmed, panic, and a loss of rationality can characterize crises. A person in crisis may not be able to solve problems or see alternatives open to them. The objective of crisis intervention is to return people to a state in which they can resume coping through supporting the thinking, cognitive part of the person until recovery occurs.

The "ABC" model of crisis intervention described by the Suicide Prevention Center, Inc. of Dayton (1982) has three basic steps:

A. *Achieving* contact with the person.
B. *Boiling* the problem down to specifics
   -Information gathering
   -Joint conclusion on problem
C. *Coping* actively with the problem.
   -Problem solving
   -Summary

Achieving contact involves establishing a relationship with the person in crisis. Rapport may be gained by focusing on the patient's emotions and being explicitly empathic. It is important to let the person in crisis know that their feelings are heard and understood. Confidence, genuineness, and warmth help to establish a trusting relationship that will enable the patient to risk sharing his problems.

Boiling the problem down involves gathering information on what is happening and then coming to a joint conclusion about the nature of the problem. The current problem is explored while maintaining a focus on the here and now. Coping strategies already tried are examined, the patient's support system is evaluated both as a cause of the problem and a resource, needs are assessed, the patient's distress is presented as "normal", and emphasis is placed on productive behaviors. The problem should be agreed upon as the patient sees it and it should be stated in a way that makes sense to the patient so that limits can be appreciated.

Problem solving flows from a clear statement of the problem (which often implies a course of action.) Alternatives are explored and only small changes in behavior are sought. The objective is to return the patient to a previous level of functioning rather than to make major changes like restructuring personality. The patient gradually assumes responsibility for the solution of the problem and the counselor provides assurance and confidence in the patient. The support system is included in the plan, and plans for help later on (such as therapy or referrals) are made. As a final step in problem solving, the progress of the session and plans are reviewed, and future stress points are reviewed to help the patient cope with future related problems.

Contracts and the Suicidal Patient

Contracts have been suggested for use with both low and high lethality patients (Slaikeu, 1984). If the suicide risk is low, the caregiver can contract with the patient to contact the caregiver if some change brings about further feelings of hopelessness and depression and more concrete thoughts of suicide. The caregiver, of course, agrees to remain available to the patient in case this need develops.

A more direct approach is needed for the lethal patient. The goal in this case is to obtain more time and delay final decisions on suicide. Slaikeu (1984) suggests a hierarchy of contract issues which increase in terms of intrusiveness and directivity:

1. The client will not commit suicide for the next several days.
2. The client will get rid of lethal means for the time being.
3. The client will not stay alone over the weekend.
4. The client will call for help if things get worse.

By using the patient's ambivalence over dying to elicit agreement to these contracts, the desire to live (such as love for one's children) becomes a hook which may motivate agreement with the contract (Slaikeu, 1984).

In some respects, counseling elderly people who are suicidal differs from counseling other age groups. The losses that they face are real and more pronounced than with other age groups. Their capacities for growth and change may be more limited. Their needs are different. People who counsel the elderly should be alert to subtle clues that a patient may be thinking of suicide. They should also be aware of inaccurate stereotypes which exist about the elderly which could influence how the elderly cope or adapt to problems.

The major goal of therapy with older people is to alleviate anxiety and maintain or reestablish psychological functioning (Fry, 1986). Other goals of therapy with older people are valuable for the insight they give into older people's problems. Actualizing client potentials is a controversial goal because it may not be realistic, but it means improving patient relationships with others and helping them to become satisfied with what they have achieved. Preventing social and emotional deterioration is achieved by maintaining social contact and meaningful work, and relieving the anxiety the elderly may have about aging and death. Accepting aging may be the most important goal since all elderly clients have to contend with aging. Patients have to adjust to the losses they have experienced and also be motivated to seek whatever can enhance their present lives (Fry, 1986).

Techniques for Counseling Elderly Suicidal Patients

Osgood (1985a) offers several suggestions for counseling suicidal geriatric patients.

1. Treatment should be adapted to the resources of the individual. Standardized tests, interviewing family

members, and a detailed patient history are needed to assess the physical and mental capacities of the patient and the support network the person possesses.

2. An active, direct approach is often successful with the elderly since they tend to do what they are directed to. Defining the problem and presenting the solutions may be preferable to an exploration of alternatives. Directing the elderly person not to commit suicide may prevent the act.
3. A warm, loving, supportive environment is critical to caring for a suicidal elderly patient. Empathy, which involves taking the cognitive and emotional perspective of another person, assures them that they are understood. Unconditional positive regard fosters a feeling of acceptance and gives permission to interact with others.
4. A brief, problem centered focus is more effective than attempting to gain deep insights.
5. Listening to reminiscences or current problems can be helpful in itself.
6. Attention to one's own nonverbal signals can aid communication with elderly people. Directly face those with hearing or visual impairments. Use a tone of voice, gestures, and touching to communicate concern.
7. Treating elderly people with respect by using their titles and by not prying improves their self-esteem.
8. It is wise to keep coping mechanisms intact until some better substitute is found. Unhealthy defenses such as clinging dependency may be important mechanisms enabling an individual to survive.
9. Talking about objects in the environment may be therapeutic in helping to elicit expressions of feelings. Other elements of the environment such as television, movies, photo albums, poetry, or favorite recipes can also be springboards for discussion.
10. Short term goals are often best for elderly people because long term goals may be unrealistic for people with few years left. Understanding and accepting the aging process or making the last years the best are realistic goals. Older people may require more direction and help in attaining these goals than other age groups (Osgood, 1985a).

An Example of a Suicide Program

Many decisions regarding the treatment of suicidal patients can be made ahead of time. The institution of policies defining the actions that health care team members should take will not only ensure that appropriate actions are taken, but will expedite their execution. Both the patient and the faculty should be protected by ethical and legal policies, which should be tailored to the particular institution. Policies should specify the situations that demand action, the measures to be undertaken, team objectives, individual responsibilities, lines of communication, and procedures for review and evaluation. They should be reviewed in training and available for reference by personnel.

Tallent, Kennedy, and Hurley (1982) have described a creative program for suicidal patients in place at the Northampton, Massachusetts Veterans Administration Hospital. An institution this large may encounter suicidal patients more often than the typical nursing home, but many of their ideas could be used by smaller facilities.

At Northampton, patients who are thought to be suicidal are placed on observation status in the center of a ward of acute, hyperactive, psychotic patients. This puts them in a situation where they have to confront their problems and get a sense of perspective. After seeing sicker patients, many of them decide to try for life sustaining options again. As an added bonus, this program discourages other nonsuicidal patients from threatening suicide in hopes of being transferred to a better ward. Tallent, Kennedy, and Hurley (1982) note the importance of communication between staff members. Each day the head nurse briefs the assistants on the suicidal patient, and the assistants file frequent progress reports. Regular charting helps to keep the information up to date.

The Northampton treatment team meets weekly and consists of nurses, nursing assistants, the occupational therapist, physical therapist, recreational therapist, and educational therapist. The head nurse and staff nurses are important figures in this plan. The head nurse coordinates all communications about the patient. The staff nurse has a close relationship with the patient and provides much of the information on the patient's progress. The ward psychologist provides formal testing and psychotherapy with the goal of understanding the patient's psychodynamics and determining the extent of suicidal risk. The ward psychiatrist oversees the program and is responsible for it, making the final determination of patient status, prescribing medications, and giving guidance to team members on treatment.

Obvious hazards, such as razor blades are removed, but the patient can keep such items as belts and shoelaces because this helps foster a sense of self-esteem. The patient is in sight at all times and his location is recorded hourly. The program relies heavily on the nurse-patient relationship. The nurses are available to listen and provide support. They have found serious nurses are more acceptable to suicidal patients than happy, bubbly ones. The Northampton program treated 156 patients over 26 months with only one completed suicide. The authors feel that this intensive program is effective because although the typical patient remains in the program for a month, many leave after only a week (Tallent, Kennedy & Hurley, 1982).

Legal and Ethical Issues

It is very common for concerns about legal obligations and liability to be raised during an inservice on elderly suicide. Such questions should be answered directly, and you may wish to contact your institution's legal representative for answers to specific questions in your locale. While a comprehensive treatment of this issue is beyond the scope of this manual, some basic issues are presented for discussion.

Liability of Institutions and Professionals for Acts of Suicide

According to Meyer and Soskin (1985), most of the suicide cases filed against hospitals, hospital superintendants, or government health facilities allege that the hospital somehow failed to watch the patient or protect the patient from harm. In the case of Ray versus Ameri-Care Hospital it was determined that a hospital must provide the care needed by a patient's condition. This includes protecting the patient from self-harm [*Ray v Ameri-Care Hosp*, 400 So 2d 1127 (La Ct App 1981), cited in Meyer & Soskin, 1985].

In Ohio, the physician's duty of care is dependent upon the general level of care available. Suits can allege a failure to provide appropriate care and supervision (Meyer & Soskin, 1985).

Although both Meyer and Soskin (1985) and Pegalis and Wachsman (1982) review numerous cases where hospitals were found liable for patient suicides, Meyer and Soskin (1985) point out that in most cases no liability has been found on the part of the defendants. The reason for this is that suicidal acts are difficult to predict, and qualified professionals can not be held liable for honest errors of professional judgement. Moreover, there are limits to the care that a hospital has to provide even for a person known to be suicidal. There seems to be some recognition that it is not always possible to prevent a determined, creative person from completing suicide.

Among cases where liability on the part of the hospital was found, the negligence has generally been clear cut. In *Comiskey v. State of New York* [(1979, 3d Dept) 71 App Div 2d 699, 418 NYS2d233], a hospital was held liable for allowing a suicidal patient to leave hospital grounds whereupon he completed suicide. In this case the patient's suicidal tendencies were well known and a past history of attempts was established. An attendant who had been directed to maintain close supervision over the patient allowed him to leave for lunch. In a similar case [*Abille v United States* (1980, ND Cal) 482 F Supp 703] an Air Force hospital was held liable when nurses allowed a patient on suicide precautions to leave a ward unattended, whereupon he jumped from a window. In *Lomayestewa v Our Lady of Mercy Hospital* [(1979, Ky) 589 SW2d885] a hospital was found liable for allowing a patient in a psychiatric ward to jump or fall to her death. The hospital had failed to provide a detention screen, thereby violating administrative regulations.

Liability on the part of the hospital has been found in cases which were less straightforward, however. In *Cook v City of New York* [(1981, 2d Dept) 82 App Div 2d 72, 411 NYS2d 104] a suicide attempter who had slashed his throat was taken to an emergency room for treatment. The bleeding was stopped, but the patient was restless and no attempt was made to restrain him. When the patient sat up and became violent, a police officer shot him in self defense. The hospital was found negligent for failing to restrain the patient. In another case, [*Weatherly v State of New York* (1981) 109 Misc 2d 1024, 441 NYS2d 319] a patient was injured upon jumping from a second floor window in a state mental facility. The patient had been admitted as a suicide risk and was receiving an antidepressant and a psychotropic drug. The patient was taken off suicide precautions, despite being assessed as "highly lethal". This constituted malpractice. The act of jumping from the window, however, was not interpreted as a suicide attempt. The patient was considered to have been acting under the influence of drug-induced psychosis, and failing to observe the patient under these conditions constituted negligence.

The Right to Refuse Treatment

According to Osgood (1987, personal communication) among the old-old the most common means of suicide involves refusing food or medical care. This results simply from other methods not being available to them, and it can be very effective because the elderly are so frail. It is appropriate to ask whether a patient has a right to refuse treatment, and what the responsibilities of the caregiver are if they do.

The answer to this is not clear at all. Meyer and Soskin (1985) say that contradictory principles are represented in law. The doctrine of autonomy states that the will of the person dominates even in acts which are harmful, yet the doctrine of inviolability requires that persons be kept from harming themselves when life is at stake. Confusing the issue further, the right of privacy as interpreted by the courts defines the body as a zone of privacy and indicates we have some degree of autonomy where it is concerned. However, this degree of autonomy varies depending on the degree of disease invasion in a person's body and the prognosis. As a result, it seems that courts would have to decide the extent of each patient's right to refuse treatment based on the circumstances of their case.

The Issue of Competence

Meyer and Soskin (1985) say that competency is a central issue in the question of the right to refuse treatment because the law prohibits medical intervention without informed consent. Only competent patients can provide informed consent to medical treatment. If one

is competent, possesses knowledge concerning the treatment, and voluntarily refuses treatment, the treatment can not legally be provided.

Stanley, Stanley, and Pomara (1985) define *competency* as the capacity to understand relevant information, evaluate the benefits and risks of a procedure, and come to a reasonable decision. They point out that the competency of the elderly is a contested issue itself. Some authorities view the elderly as a mixed population with regard to competency, while others see them all as frail and in need of guardianship when facing medical treatment decisions. At present few studies have investigated the capacity of normal or psychiatric elderly populations to provide informed consent.

As a practical matter, competency is decided on a case by case basis by the courts. Lennard and Kaufman (1985) note that courts consider the specific medical question when deciding on the competency of a person to make a decision. While an impaired person may be deemed competent to decide whether a routine medical procedure may be done, the same person might not be competent to decide one with more profound consequences (such as electroconvulsive therapy). Lennard and Kaufman (1985) in reviewing the concepts of guardianship and conservatorship, show that some distinctions can be made in the level of competence a person is said to have. *Guardianship* involves the greatest loss of individual rights, such as the right to contract, to dispose of property, or the right to decide one's future. It exists for the purpose of protecting the individual both personally and financially. In California, this is now applied to minors, while the term conservatorship is applied to adults. *Conservatorships* are more limited than guardianship. The conservatee keeps most of his or her legal or civil rights. With conservatorships, people retain the right to make medical decisions, although decisions about property or decisions relating to food and shelter may be made for them (Lennard & Kaufman, 1985).

Involuntary Detention (as acheived through probate court in Ohio) is the result of a procedure to have an impaired person committed or detained. A great degree of impairment is required for involuntary detention. As a rule, only persons suffering from alcoholism, drug addiction, or a grave mental disorder are involuntarily detained. This may apply to persons with diseases such as dementia. However, the trend is to respect individual autonomy as much as possible.

The Family's Role in Treatment Decisions

According to Lennard and Kaufman (1985), the family has no right to decide medical treatments for an individual who has not been ruled legally incompetent. Adults are competent unless they have been ruled incompetent, and they themselves retain the legal right to make medical decisions. Proceeding with treatment of a competent patient on the grounds of family consent constitutes battery and negligence on the part of the caregiver. Exceptions are made for emergency conditions that are very serious or life threatening, where there is no opportunity to gain informed consent from the patient, or if the patient is legally incapable of granting it. As a rule, however, the caregiver should encourage the family to obtain the legal status required to make the decision. While the proceedings needed to gain legal authority may be degrading to the person, it is the only way for the caregiver to avoid acting illegally and being compromised in possible future litigation (Lennard & Kaufman, 1985).

Resources

A List
for
Butler, Clark, Darke,
Greene, Montgomery, and Preble Counties.

GENERAL RESOURCES, ALL COUNTIES:

Nursing Home Ombudsman Program ..... (513) 223-4613

Bonnie Macauley, Ombudsman
Center City Building
15 East 4th St.
Dayton, OH 45402

-Complaints against nursing homes
-Help with Medicare, Medicaid, and Social Security programs
-Help with starting volunteer visitation programs.

Area Agency on Aging Unit of the United Way ..... (513) 225-3027

Doug McGarry, director
184 Salem Avenue
Dayton, OH 45406

-Service area does not include Butler County
-Social Service Programs
-Administers Older American Act funds
-Advocate for senior citizens

Council on Aging of the Cincinnati Area, Inc. ..... (513) 721-1025

-Serves Butler County

BUTLER COUNTY:

Access ..... (513) 424-5498

64 South Main St.
Middletown, OH 45052

Crisis Line Butler County Mental Health Center ..... (513) 896-7887

111 Buckeye Street
Hamilton, OH 45011

Middletown Area Mental Health Center ..... (513) 424-5498

64 South Main Street
Middletown, OH 45042

Middletown Senior Citizens ..... (513) 423-1734

9 City Centre Plaza
Middletown, OH 45042

Oxford Crisis and Referral Center ..... (513) 523-4146

14 South Campus Avenue
Oxford, OH 45056

Oxford Senior Citizens, Inc ..... (513) 523-1717

922 Tollgate
Box 381
Oxford, OH 45056

Pro-Seniors of Cincinnati ..... (513) 621-0186

201 Executive Bldg.
351 East 7th St.
Cincinnati, OH 45202

Senior Citizens, Inc. ..... (513) 895-6980

140 Ross Avenue
Hamilton, Oh 45013

CLARK COUNTY:

Elderly United of Springfield and Clark County, Inc. ..... (513) 232-4948
(513) 323-2871

101 South Fountain Street
Springfield, OH 45502

Information and Referral ..... (513) 323-1400

1101 East High Street
Springfield, OH 45505

Suicide Prevention Center Life-Line ..... (513) 322-5433

1101 East High Street
Springfield, OH 45505

DARKE COUNTY:

Darke County Mental Health Center ..... (513) 548-1635

212 North Main St.
Greenville, OH 45331

Senior Assistance Program ..... (513) 548-2727

c/o Council on Rural Service Programs
116 East 3rd Street
Greenville, OH 45331

Senior Life Line ..... (513) 548-2727

214 North Main Street
Greenville, OH 45331

GREENE COUNTY:

Golden Age Senior Citizen's Center ..... (513) 376-4353

130 East Church St.
Xenia, OH 45385

-Retired senior volunteer program
-Outreach, health services, special programs, transportation, meals

Greene County Crisis Center ..... (513) 376-8701
426-2302

452 W. Market Street
Xenia, OH 45385

Greenwood Manor of Greene County ..... (513) 367-7550

711 Dayton-Xenia Road
Xenia, OH 45385

-Custodial unit for residents who do not need nursing care
-Nursing home

Information and Referral ..... (513) 372-9983
426-8289

130 W. Second Street
Xenia, OH 45385

Mental Health Resources ..... (513) 376-8700
Hotline: ..... (513) 376-8701
(513) 429-0933

452 West Market St.
Xenia, OH 45385

-Elderly specific mental health services, geriatric counselors
-Home visits if needed

Senior Citizens Association of Metropolitan Fairborn ..... (513) 878-4141

14 North Central Ave.
Fairborn, OH 45324

-Volunteer program, outreach, health programs, special programs

Senior Citizens, Inc., Yellow Springs ..... (513) 767-5751

227 Xenia Avenue
Yellow Springs, OH 45387

-Programs, transportation

MONTGOMERY COUNTY:

Contact Dayton ..... (513) 296-7888

P.O. Box 255
Dayton, OH 45401

Information and Referral ..... (513) 225-3000

184 Salem Avenue
Dayton, OH 45406

Montgomery County Development Corporation ..... (513) 225-6328

1700 Miami Valley Tower
40 W. Fourth Street
Dayton, OH 45402

-Lifetime Loan program offers no & low interest loans to 62 and over.

Ombudsman Office ..... (513) 223-4613

15 East 4th St., suite 208
Dayton, OH 45402

Senior Citizens Center of the Greater Dayton Area ..... (513) 223-8246

105 South Wilkinson St.
Dayton, OH 45402

-Travel program, volunteer program, outreach, adult protective services, health programs, special programs, kosher congregate meals, nutrition program, on-site services, senior community service employment

Suicide Prevention Center ..... (513) 223-9096
Hotline: ..... (513) 223-4777

P.O. Box 1393
Dayton, OH 45401-1393

PREBLE COUNTY:

Preble County Community Action Committee ..... (513) 452-3326

103 US Route 127 South
Camden, OH 45311

-Provides comprehensive client services for all age groups
-Home delivered and congregate meals for the elderly

Preble County Council on Aging ..... (513) 456-4947

Alice McMann, Executive director
215 South Franklin St.
Eaton, OH 45320

-Activity Center
-Outreach and Counseling, Homemaking and Chore assistance, transportation, visits.

Preble Counseling Center Hotline ..... (513) 456-1166

David Miller, Director
101 North Barron St.
Eaton, OH 45320

-Geriatric program: counseling geared to older adults, home visits.

Preble County Services for the Elderly ..... (513) 456-4947

310 South Barron St
Eaton, OH 45320

United Way Emergency Information and Referral 1-800-321-2457

201 East Main Street
Eaton, OH 45320

Suggested Inservice Lesson Plans

Introduction

These lesson plans are intended to be workable inservice outlines for nursing home, high school, college, and graduate level instruction. They are designed to last from one to one and one-half hours, which includes video and small group discussion times. They can be amended to address issues that you think are important for your staff or situations that may exist in your institution. Handouts are included which can be replicated for distribution to staff. The outlines all follow the same basic plan of a presentation followed by the video. The session ends with small group discussion around topics related to elderly suicide.

Small Group Process

The lesson plans make substantial use of small group process. This method of learning encourages participants to draw upon their experiences as well as materials they are exposed to in the session. Learning is enhanced by interaction around the chosen topic, by exposure to other's opinions, and by the opportunity to make these issues personal ones.

Small group process seems to work best when groups are limited to six or seven individuals. Groups should isolate themselves geographically for discussion, perhaps by drawing their chairs into a circle or having their own tables to sit around. Each group appoints a spokesperson to record the major points of group discussion. Groups interact around issues for ten minutes or so, and then the spokespersons relay their reflections to the inservice presenter, who typically writes these down on a chalkboard or newsprint easel and adds any appropriate additional remarks. Discussion and comments from the floor are also welcome at this time.

Lesson Plan I
Basic level

Purpose

This session is meant to provide the participant with an understanding of the psychodynamics of elderly depression and suicide. The signs and symptoms of depression and suicidal activity as well as some techniques of intervention are reviewed.

Objectives

At the end of this session, the learner will be able to:

1. Identify losses of old age.
2. Identify signs and symptoms of elderly depression and suicidal ideation.
3. Distinguish between depression and sadness.
4. Understand suicide as a spectrum of behavior, not all of which immediately ends in death.
5. Understand the stress model of suicide.
6. Make interventions based on this understanding of suicide and depression.
7. Appreciate the need for communication among the nursing staff and know who to inform if a patient is suspected of being depressed or suicidal.

Handouts:

-Signs and Symptoms of Depression -Stress Model of Suicide -Clues to Suicide

Outline

A. *Presentation*: 20 minutes

I.	Statistics (Brief!)	1. 25% nursing home population estimated depressed (Fry, 1986). 2. Suicide rate highest for elderly white males (see figure 3). 3. Suicide rate in nursing homes comparable to general population.
II.	Depression	1. A definition of depression (handout of signs and symptoms); depression and sadness. 2. Reactive model of depression; discussion of losses of old age and diminished coping abilities.
III.	Suicide	1. A definition of suicide as a spectrum of self-destructive behavior (risk taking, hastening death, self-neglect). 2. Stress Model of Suicide (handout). 3. Clues to Suicide (handout).
IV.	Intervention	1. Providing emotional support; empathy, countering feelings of isolation. 2. Communication among staff. 3. What to do in the event of a crisis.

B. *Video Presentation*: 26 minutes

C. *Small Group Discussion*: 10 minutes

Small Group Discussion Topics:

1. Was Pat depressed? Could you have known he was suicidal?
2. How did Pat show those around him how he was feeling?
3. Who had the best response to Pat? What made their response the best?
4. How would you handle a person like Pat in your institution?

D. *Small Group Summary Reports*: 10 minutes

Lesson Plan II
Intermediate level

Purpose

This session is meant to provide an understanding of the etiology of elderly depression and suicide. Special emphasis is placed on assessing suicide risk and lethality, and reviewing interventions that may be necessary (crisis intervention, contracts, and suicide watches).

Objectives

At the end of this session, the learner will be able to:

1. Identify signs and symptoms of elderly depression and suicide.
2. Understand the "stress" and "stages of suicide" models of suicide, and use them to evaluate clients.
3. Assess suicide risk and suicide lethality.
4. Understrand the measures involved in a suicide watch.
5. Understand a simple method of crisis intervention.

Handouts:

-Signs and Symptoms of Depression
-Stress Model of Suicide
-Stages of Suicidal Thought
-ABC Crisis Intervention Model

Outline

A. *Presentation*: 30 minutes

I.	Statement of Problem (Brief!)	1. Although only 2-5% of nursing home residents are clinically depressed (Blazer, 1982), actual instances of depressive symptoms are higher (25% residents depressed, Fry, 1986). 2. Suicide in older people is primarily an elderly white male phenomenon. 3. Suicide in nursing homes happens at same rate as in general population (Osgood, 1987). 4. Risk over 75 is greatest from ILTB.
II.	Depression and Suicide	1. Definition of Depression emphasizing difference in elderly depression (handout of signs and symptoms). 2. Stress model of suicide (handout). 3. Stages of suicide model of suicide (handout).
III.	Intervention	1. Quick review of ABC crisis intervention model (handout). 2. Discussion of contracts. 3. Review of suicide watch policies at your institution. 4. Review of policies for dealing with depressed or suicidal people at your institution.

B. *Video Presentation*: 26 minutes

C. *Small Group Discussion*: 20 minutes

1. Small Group Discussion Topics:
   1. How did Pat typify a suicidal person? How was he unusual?
   2. How would you assess Pat's suicide risk? What would it be? How lethal was he?
   3. How would you respond if another worker told you about Pat's refusal to go out with his family?

D. *Small Group Summary Reports*: 20 minutes.

Lesson Plan III
Advanced level

Purpose

This session is meant to provide the participant with a review of the dynamics of depression and suicide and provide an awareness of suicide as a problem in nursing homes. The policies and procedures of the institution are emphasized since the participants are people likely to coordinate efforts to help a depressed or suicidal person.

Objectives

At the end of this session, the learner will be able to:

1. Identify the signs and symptoms of depression and suicidal activity.
2. State how depression can be confused with other conditions.
3. State conditions under which a request for a psychological referral would be made.
4. State the policies and procedures in place for dealing with depressed or suicidal people.
5. State some guidlines for counseling suicidal elderly people.

Handouts:

Signs and Symptoms of Depression
Stress Model of Suicide
Counseling Techniques

Outline

A. *Presentation*: 30 minutes

I.	Statement of Problem (Brief!)	1. Prevalence of depression and suicide in nursing homes.
II.	Depression and Suicide	1. Signs and Symptoms of depression (handout). 2. Endogenous and exogenous depression. 3. Difficulties in diagnosis. 4. Depression and Pseudodementia. 5. Stress model of suicide (handout).
III.	Intervention	1. Medications. 2. Discussion of when to ask for referral for psychological evaluation. 3. Discussion of guidlines for working with suicidal elderly (handout).
IV.	Policies	1. Need for policies; policies existing with regard to depression and suicide.

B. *Video Presentation*: 26 minutes.

C. *Small Group Discussion*: 20 minutes

1. Small Group Discussion Topics:
   1. What good things did the staff do prior to Pat's attempt?
   2. How did policies or the lack of them help or hurt the staff of this nursing home?
   3. How would Pat have been handled differently at your institution?
   4. What changes in existing policies could be made to increase the likelihood that a suicidal person could be identified and helped?

D. *Small Group Report Summary*: 20 minutes

Signs and Symptoms of Depression

Depression is the most common psychological disorder of old age. Depression is usually defined in terms of *mood*. The mood may be one of despair, emptiness, or numbness.

Older people often show depression differently than younger people. They may be

anxious

preoccupied with physical symptoms

fatigued

withdrawn

slow to move or think

apathetic, inert, disinterested in their surroundings, and lacking in drive.

The signs and symptoms of elderly depression include:

1. A sad, depressed mood marked by feelings of helplessness, hopelessness, despair, sorrow, guilt, or blaming others. Conversely, depressed older people may also be anxious, inert, or disinterested.
2. Bodily, physical complaints (hypochondriasis). Patient may not verbalize feelings.
3. Agitation or retardation of activity or thought.
4. Social withdrawal and isolation
5. Significant loss of appetite and weight, or increased appetite and weight gain.
6. Change in sleeping or eating patterns.
7. Extreme fatigue.
8. Confusion and inability to do simple tasks.

Clues to Suicide

As a person considers suicide, there are verbal, behavioral, and situational clues.

VERBAL CLUES:

Direct Statements such as "I'm thinking of killing myself" or "I'd be better off dead."
Indirect statements such as "You won't have me to worry about anymore" or "I'm fed up with everything."
Hinting at death or joking about death. Saying goodbye to significant others.

BEHAVIORAL CLUES:

Death themes in writing or artwork.
Listening to sad music or the same song repeatedly.
Making or changing a will.
Increase in alcohol or drug use.
Giving away personal items.
Changes in eating or sleeping routines.
Personality changes.
Self-destructive acts or accidents.
Getting affairs in order.
Isolating self from family or loved ones.
Making others angry so they will stay away.
No longer touching others or liking touch as they once did.
Nervous touching of neck or wrists.
Posture resembling fetal position.

SITUATIONAL CLUES:

Any major change in a person's life, good or bad.
Elderly white males.
Loss of loved one to death - especially loss of spouse.
Social isolation, especially from family or friends.
Change in environment - even from one ward to another within an institution.
Chronic, active illness.
Depression.
Economic difficulties.
Previous suicide attempts.

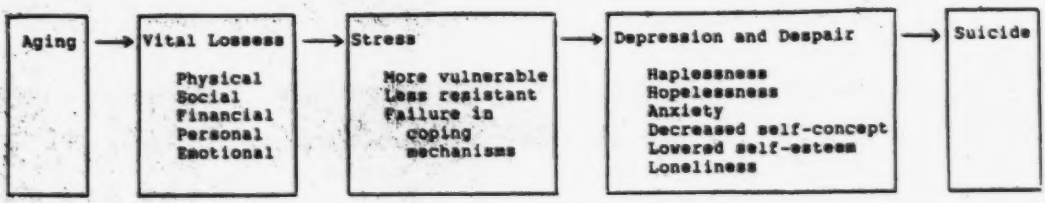
Risk Factors in Elderly Suicide

1. *Race*: White, Chinese-American, Filipino-American
2. *Age*: Highest risk over 75
3. *Sex*: Male, especialy white males
4. *Marital Status*: Unmarried, especially bereaved
5. *Work Status*: Unemployed, retired
6. *Environment*: Socially isolated, especially from family and children
   Low income urban areas
   Risk higher with institutional admissions and discharges, and moves within an institution
7. *Religion*: Higher risk if no religious beliefs
   Risk higher for Protestants than Catholics or Jews
8. *Health*: Active chronic illness, painful or terminal illness
9. *Substance Abuse*: Especially alcoholism
10. *Bereavement*: Especially death of spouse
11. *Psychological Syndromes*:
    Depression: (2/3 of elderly attempters are depressed)
    Tension and Agitation
    Guilt and Dependency
    Anxiety Disorders:
12. *Economic Difficulties*
13. *Previous Suicide Attempt* or loss of loved one to suicide
14. *General Interpersonal Problems*: including sexual problems

Adapted from Tideiksaar, 1985; Osgood, 1985a & 1987; and Maris, 1981.

The Stress Model of Suicide

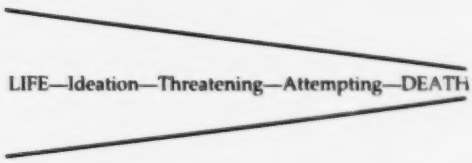
Osgood (1985) proposes that the losses of old age produce stress which causes elderly suicide. When losses such as retirement or health occur, older people rally and resist the stress at first, but eventually they become exhausted and succumb to depression and suicide. Since older people are not as strong or adaptable as younger ones, they can't bear stress as well. Older people also have fewer resources (such as money and friends) at their disposal, and they are less able to cope with the problems they have. The progression from aging to losses to stress to depression to suicide is not inevitable. It can be halted by taking measures to prevent unnecessary losses (as to health), remove stress or enable people to cope with it, and providing emotional support.



Stages of Suicidal Thought

Stages of Suicidal Thought

Another model which involves stress and an inability to cope with it uses Stages of Suicidal Thought (Suicide Prevention Center, 1986). This model assumes that people are always ambivalent about the idea of suicide. At the same time they are drawn to life, they are drawn to death as a way to escape the pain they feel.



Stages of Suicidal Thought Model

As people become more and more suicidal, they are less able to see other solutions to their problems. They might not be able to remember resources they have, such as friends. Even emotions may be suddenly unavailable to them. This narrowing of perspective and ability is called "tunnel vision," and is represented by the converging lines in the diagram above. It is strongest for a person attempting suicide.

Important points of these stages are shown below:

Ideation
-Life theme is stronger than death theme.
-Can see some solutions to problems.
-Will discuss and act upon life-oriented ones.
-Suicide a distant option.
-May last hours or years.

Threatening:
-Pain makes death theme as strong as life.
-Feel no one hears their needs.
-Pronounced tunnel vision, low level of coping.
-Low ability to discuss problems or act on them.
-May last days or weeks.

Attempting:
-Death theme stronger than life.
-Tunnel vision extreme; death is only alternative.
-May feel they have looked at all alternatives and be unwilling to discuss options.

ABC Crisis Intervention Model

The "ABC" model of crisis intervention (Suicide Prevention Center, 1982) has three basic steps:

A. *ACHIEVE* contact with the person
- -Establish a relationship
- -Let person in crisis know their feelings are understood
- -Build trust by showing confidence, genuineness, and warmth

B. *BOIL* the problem down to specifics
1. Information gathering
   - -Maintain focus on here and now
   - -Look at what has already been tried
   - -Assess needs and resources, support system
   - -Assure that distress is normal
2. Joint conclusion on problem
   - -State problem as patient sees it so limits can be seen

C. *COPE* actively with the problem.
1. Problem solving
   - -Explore alternatives
   - -Look for only small changes in behavior
   - -Include support system in plan
   - -Plan for help later on (therapy, etc.)
   - -Let patient assume responsibility; provide assurance
   - -Goal is to return patient to previous level of function
2. Summary
   - -Review progress of session and plans
   - -Anticipate future stresses

Techniques for Counseling Elderly Suicidal Patients

Osgood (1985) offers the following guidelines for counseling suicidal geriatric patients:

1. Adapt treatment to the resources of the individual.
   Assessment: -Physical and mental capacities
   -Support system
   Method: -Standardized tests
   -Interviewing family members
   -Detailed patient history

2. Provide an active, direct approach.
   Define problem, present solutions
   Directing elderly person not to commit suicide may prevent the act

3. Provide a warm, loving, supportive environment.
   Assure patients they are understood
   Acceptance gives permission to interact with others

4. Atempt tp use a brief, problem centered focus rather than attempting to gain deep insights.

5. Listen to reminiscences or current problems.

6. Use nonverbal communication techniques:
   Use concerned tone of voice, gestures, touching
   Directly face patients with hearing or seeing impairments.

7. Treat elderly people with respect by using their titles and by not prying; can improve self-esteem.

8. Keep coping mechanisms intact until some better substitute is found. Dependency or other coping skills may be keeping a patient alive.

9. Elicit expression of feelings.
   -Talk about objects in the environment
   -TV, movies, photo albums, poetry, or favorite recipes may be conversation starters.

10. Use short term goals as these are often best. This is most realistic with few the limited life span of the elderly. Understanding and accepting aging is a good goal. Older people may require more direction and help.

Script of Videoproduction

Title: A Season of Loss

Suicide in the Elderly Video	Audio
Paramedics are rolling Pat to the ambulance. They put him in. Cut to lights flashing and ambulance drives away. Cut to residents reaction.	Paramedic #1: Respirations are 6. Paramedic #2: (He turns and looks down at Pat and reads heart monitor as he pushes the stretcher to the ambulance. Resident #1: That is Pat. They found a suicide note beside his bed.
Susan walks into shot. background video: paramedics, ambulance and nursing home residents	Susan: There's been alot of media attention on teenage suicide. This is a national problem, but, officials say there is a different age group that is being overlooked. Elderly people who are sixty-five and older, are more likely to kill themselves than any other age group. Elderly people make up about eleven percent of the population. Out of that eleven percent, people sixty-five and older contribute to seventeen percent of the suicides a year. Seventeen percent may not sound like much, but when added up, it is about forty eight hundred deaths a year. A disorder in mood is usually what leads elderly people to commit suicide. Depression . . . especially in elderly people is hard to detect, since they often don't make overt, easily recognized statements that indicate they are depressed. This video tape will show you some behavioral patterns of depression in the elderly. You just saw results of a seventy year old man who attempted suicide. The Victory Nursing Home staff caught it in time, but right now they're trying to understand what happened, how Pat was different from other residents, and how to help Pat when he returns . . .
Video	Audio
Nursing Home Conference Room	Ann: You know what gets me about all this? I keep thinking I should have seen it coming. Pat's been with us for three months now. He's a classic case. He's a widower. He's lost his home, friends, job . . . you name it, he's lost it. He even updated his will last week. Yet, Pat didn't appear to be that depressed before. His attempt really surprised me. Betty: I don't think any of us were expecting it. We're probably all feeling a little guilty. Ellen: I'm sure we're all having alot of second thoughts about Pat, but for now let's look at what went on with him and see if there was anything to show how desperate he was. Edna: That won't be easy. Like Ann said, Pat has had alot of losses, but so has everyone else here. And making wills, getting cemetary plots, and getting ready for death is something our older residents normally do. Ellen: What behaviors made Pat different from other residents? Betty: When Pat first came here he had trouble adjusting to being in the home. More than patients usually do. Tom: That's for sure. We remember the first weekend his family came to sign him out . . .
Dissolve to Front desk at nursing home.	

Tom and Betty are behind the desk when Pat's daughter comes to sign him out. (They are in the background and will watch everything that happens).

Jill: Hi, Dad, are you ready to go?

Pat: Hell, yes, I'm ready to go. I can't wait to leave. They run this place like a prison. They tell me what time I have to get up in the morning. They tell me when I have to eat. They're even making me share a room with a guy who snores all night long. You wouldn't want to get up at six in the morning either if you couldn't sleep all night long because of all the noise. Jill, I can't believe you would put your own father in a place like this. I'm not going with you this weekend. Just forget it.

Pat walks back to his room.

Jill: Dad, wait . . . Dad I have the weekend . . . pl . . .

Betty follows Pat to his room.

Betty: Pat, it seems like you're upset with everything that goes on here. I get the idea that coming to our home
was a hard thing for you to do.

Pat: It wasn't easy, that's for sure.

Betty: How was it hard for you?

Pat: I had to give up so much. Look at me now. I don't have a home anymore, or a car, either. Even my room I have to share with some guy I never saw before. How would you like living here?

Betty: I wouldn't like losing all that at all . . . it would be very difficult. However there are times when we need extra care for ourselves.

Pat: Taking care of folks is fine. But here there's always someone looking over my shoulder. They tell me when to take my diabinese and when I've got to clean up. They keep track of where I go and what I do. I can't even leave this place without being signed in or signed out. I used to be a responsible adult, two weeks ago. I was even a head postal clerk once. Here, they treat me like a five year old.

Betty: It sounds like you feel upset . . . because you're feeling a loss of control and maybe your not getting enough responsibility for taking care of yourself.

Pat: I guess that's one way of putting it.

Betty: Pat, we think you should take care of yourself as much as you can.

Pat: Then why are you always checking up on me?

Betty: We just want to help, Pat. In some ways, you need our help now.

Pat: (Sighs) Yeah, that's the truth.

Dissolve to Staff meeting.

Betty: I tried to talk to Pat about things he could do for himself several times, but he never wants to take responsibility for his own self care. And when we gave him more concrete tasks like watering the plants, and wrapping silverware, he really resented them. It was really frustrating.

Ellen: Maybe its up to us to do some additional research to find out what Pat may be interested in.

Ann: Thats a good idea. Pat may not have been open to sharing with us in the past about his areas of interest. If both Social Services and Activities makes a concentrated effort, by doing some additional assessments . . . we will find some "hidden talent" or interest we hadn't discovered yet. In fact we should add this problem directly to the plan of care.

Betty: Maybe one of you could contact the Director of Nursing again to see if she has any further suggestions.

John: Once we come up with a reassessment of interests, I will work to develope an individual activity and then some small group activities that Pat can be successful in. These activities should promote self esteem.

Video transition to Greg and Linda. Zoom out.

Linda: The Victory Nursing Home staff had some good suggestions of how they could help Pat, didn't they Greg?

Greg: Yes they did. Their ideas of doing additional research through the Social Service Assessments and through the Activities Assessments will really help Pat. The staff could also call Pat's family to find out any additional interests he hadn't shared. Once the staff comes up with a reassessment of interests for Pat, I think they will be very successful in re-adjusting him into the nursing home.

Linda: Thats true Greg. Pat really needs some help re-adjusting to the nursing home. He is having more trouble than most residents do. Adjusting to a nursing home is an important factor in elderly suicide. Other important factors include the loss of a spouse, losses associated with retirement such as income, routine, status, identity and physical losses, and losses of friends and community. One of the leading authorities on suicide in the elderly, Dr. Nancy Osgood, says in nursing homes particularly there are three factors which are associated with the initial move into nursing home. Beyond having to give up one's home and possessions, many see the nursing home as a place they will die in. Surprisingly, moving within the nursing home is also a significant risk factor. Sometimes these moves are mandatory, as when a resident changes from skilled to intermediate level of care and has to be moved to a different unit. This deprives the resident of continuity in their environment and relationships. A final factor is a feeling of being rejected by one's own family. This can occur even with patients whose family members visit them every day, because once the visit is over they still have the rest of the day to feel deserted and abandoned.

Greg: Ok . . . Now lets take a look at what else made Pat different from the other nursing home residents.

Dissolve to recreation lounge. Some nursing home staff are sitting at a card table. They are playing cards. Pat is sitting by himself on the couch. John sees him and walks over to Pat.

John: Pat, why aren't you playing cards?

Pat: I haven't played cards since my wife died.

John: Since your wife died!

Pat: We used to play cards with our neighbors every other Sunday afternoon. At least until Joan got sick - then we never played much. I tried after she died, (pause) but I just couldn't handle it. I kept thinking about her.

John: It sounds like even now thinking about her is very painful for you.

Pat: (no response)

John: How long ago did she die, Pat?

Pat: Two years. She had a stroke, then she had another.

John: Was she sick long?

Pat: Too long. She never did anything to deserve it. We'd always thought that when I retired we'd get a camper and tour the country. I retired. Then she had a stroke. She lost movement on her left side and spent most of her last year in bed. She also had some trouble speaking, but she was still sharp. God, it was hard to see her like that.

John: Hopefully she's happier now.

Pat: How can you say that? She's dead. Dead.

John: You think about her a lot, don't you Pat?

Pat: Well, what else is there to think about? No cards today, thank you. And I think I'll watch some TV.

John: O.K., Pat. Let me know if you want to talk some more about this, O.K.

Dissolve to staff meeting

John: So Pat is still feeling strong grief over his wife two years after she died.

Ann: Grief that's intense after a couple of years isn't healthy. Pat isn't letting go.

Tom: Yeah. And Pat's always lonely, but he never does anything to change it.

Dissolve to phone ringing in Pat's room. Pat answers, it is his daughter Jill. After Pat says hello cut between Jill and Pat on phone.

Pat: Hello.

Jill: Hi Dad, I just called to tell you that we will pick you up tomorrow around eleven o'clock.

Pat: For what?

Jill: Dad, it's Father's Day. I told you we were planning to take you to the church's Father's Day Picnic.

Pat: Father's Day Picnic. I don't want to go to a Father's Day Picnic.

Jill: But Dad, all of us have been looking forward to taking you with us to the picnic . . .

Pat: (Pat interupts her). Jill I just don't want to go and that is that! Good-bye. (He slams down the phone).

Pat hangs up and Tom walks into the room. Bob tells Tom what just happened.

Bob: Hey, Tom, do you think it's right for a fella to skip out on his own Father's Day party?

Pat: There is no party.

Tom: What Party?

Video of Tom and Bob and Pat.

Bob: Pat's daughter just called him a while ago asking if he wanted to go out to a party tomorrow - which is Father's Day. He said "no."

Pat: Bob, it's just a picnic, not a Father's Day party.

Tom: You don't want to go with them, Pat?

Pat: No, I don't. They've got their own lives to live. That's why I'm here to begin with. And besides, I know for a fact they're busy that day.

Bob: Oh, come on, Pat.

Pat: Jerry has Cub Scouts every Sunday. Jill has the church circle, and Ron plays golf.

Tom: Sounds to me like they're going on a picnic Sunday, Pat.

Pat: Even if they are, they don't want an old guy like me around.

Tom: Why not?

Pat: Ask Them. They put me in here.

Tom: You seem to feel they don't want you around.

Pat: Maybe they don't.

Bob: Pat, they just couldn't take care of you. That's all.

Pat: Or they didn't want to.

Tom: Yet, your family seems very concerned about you. I notice they come out here every week to see you.

Pat: I think they do that because they think they have to. Or so they don't feel guilty about it.

Tom: How do you feel about them, Pat?

Pat: They've left me here. Even if they come every week, they leave me alone here most of the time. And that's O.K. Like I said, they've got their own lives. I don't want to be with them right now. So I don't think I should have to.

Dissolve to staff meeting.

Tom: I did report this incident to the social worker.

Ann: And I did follow up, but Pat was very resistive about talking about his relationship and his family.

John: It isn't only his family either. Pat is always staying away from people. He doesn't join our groups or seem to have as many friends as the other residents. I remember lots of times when everyone else has been talking or doing something, and Pat was off in a corner looking out the window.

Edna: I work nights so I never get to see that kind of thing, but I do know Pat has been having trouble sleeping lately. And he's usually been brooding over his problems when he's been up at night. A couple of times last week I found him coming up the hall at two in the morning, heading for the TV lounge.

Betty: He told us he couldn't sleep because he can't stand his roommate snoring all the time. So I suggest we assign him to a different room.

Ann: Betty that is a good idea. In order for it to work, we need to carefully match Pat with an appropriate resident, and take time to introduce him to the resident. Also we need to give, Pat the choice of saying yes or no to this move.

Edna: I think I know of a resident who has similar interests as Pat. I bet they would get along really well.

Ellen: I have a suggestion to help Pat. Why don't we have a family conference and discuss Pat's problems and ask for their suggestions. A solution we might come up with is . . . maybe they could visit him more than usual until Pat gets re-adjusted.

Video transition to Greg and Linda.

Linda: Greg are these symptoms of Pat's signs of depression?

Greg: Yes Linda, Pat turning his family down and never participating in the activities in the nursing home are some good examples of depression. The signs and symptoms of depression are usually: a loss of interest or pleasure in usual activities, a sad or depressed mood, a negative self image, feelings of worthlessness or guilt, difficulty concentrating, or recurrent thoughts of death or suicide. We also look for shifts in levels of several things. A person's activity level may decrease so they are lethargic and sleep all the time or their activity level increases so they become agitated and suffer insomnia. They may also lose weight through not eating or gain weight because they are overeating.

Linda: Can the nursing home staff change some of Pat's depressed symptoms with their suggestions?

Greg: I can't guarantee that any one suggestion or idea will change anything, but from my experience their suggestions should help Pat.

Linda: Alright then . . . lets take a look at one more symptom the staff noticed that made Pat different from the other residents . . .

Pat is sitting in a pew, his walker by his side. The other residents file out and Sr. Mary George stops to talk with him.

Pastor: Good to see you again, Pat.

Pat: You too, Pastor Strobel. You know, you talked about our purpose in life in your devotion. I wonder how you relate that to being in a nursing home.

Pastor: God has purposes for us here, too, Pat. If He didn't we wouldn't be here.

Pat: Do you know what it might be?

Pastor: It's different for everyone. You sound like you wonder about the purpose of your own life right now.

Pat: I don't know if I'd put it that way.

Pastor: How would you put it?

Pat: My kids are grown. Joan's gone now, and so are alot of my other friends. I'm retired. And I've done the things in life I've wanted to. Maybe I've done everything I'm supposed to.

Pastor: How is it for you to feel that way Pat?

Pat: I don't know how I'm feeling. It's kind of empty because I don't know what I could possibly have left to do now.

Pastor: It seems to me like many of us feel that way at one time or another. Yet, we have to have faith, Pat, and trust in God. His purposes are sometimes hard to see, but they're there. You can count on that.

Pat: Yes, that's what they keep telling me.

Pastor: You don't sound very convinced.

Pat: I keep thinking if I had a purpose, I would be aware of it.

Pastor: Perhaps it's there and you just need some time to reflect on it or someone to talk with to sort it out. I'd like to be able to talk with you about this after lunch, Pat.

Pat: That's fine with me.

Pastor: After lunch, then.

Video transition to staff meeting.

Pastor: After lunch we got together and went around on this for close to an hour. I had the feeling he didn't really want to look for a purpose, but was just playing "yes, but" with me. But maybe a purpose was just out of reach for him, because he was feeling useless.

Ann: It sounds like when he was talking to you he was feeling pretty useless and helpless.

Betty: I've heard alot of situations where Pat is described as feeling useless or helpless. Helplessness is a big part of depression.

Ellen: (Pause). That's right. I know Pat won't feel helpless if we execute our ideas that we mentioned before. The ideas of additional Social Service Assessments and Activities assessments are good. The results of the assessments can help John plan an individual activity for Pat. I know this will help Pat get readjusted. (Pause) Can anyone think of anything else unusual about Pat? (Pause) Well, what else can we do to help him or us when he comes back?

Betty: Well, we also have to keep in mind your suggestion . . . Ellen . . . About holding a special family conference. I also think it would help us alot if we kept open communication about what's going on with Pat.

Ellen: I've been thinking about that. It might help if we had a policy of guidelines to follow if we suspect someone is depressed or suicidal.

John: Maybe if we see Pat or someone else, with symptoms of depression, we can mention it to the social worker to make an assessment.

Ellen: Right. And after Ann makes her assessment, she may determine that a psychological evaluation is needed. I could request an order for this evaluation from the resident's physician.

John: I think for all of this to work, we've still got to be sensitive to what our patients are feeling.

Ann: Another thing we should do is talk to Pat about being suicidal. If he is having these feelings, he needs permission and an opportunity to talk about them.

Edna: Is that a good idea? We can't just ask people if they're thinking of killing themselves.

Ann: If we have reason to think they are, why not ask? You can't put the idea in their heads and if they are suicidal they may really need to talk.

Edna: I guess that's right. Next time I'll check it out with them, or bring it to someone who can.

Ellen: I'm sure we all will.

Video transition to Greg and Linda.

Linda: Greg, I think the Victory Nursing Home staff's idea of keeping communication going between them about unusual behaviors in residents is a good one. If they see a resident whose behavior shows signs of symptoms of depression that lead to suicide, they should first report the incidents to the nursing director and social worker. If they are receiving alot of reports on that particular resident, then it's time to have a special care conference to open up the communication lines between the staff. This way they can all get a bigger picture of what is happening, and their ideas that they come up with will really help the resident. Greg, do you have any suggestions that they should keep in mind when talking to nursing home residents?

Greg: Yes, If you suspect a resident may be depressed, it is helpful to keep some things in mind when you talk to them. First it's important to establish a rapport with them because they will have to trust you before they'll share sensitive feelings. This means being patient and sometimes holding threatening or distressing questions until you've talked with them several times. Older people also have limitations which younger people don't. Since their attention span is more limited, prolonged discussions are less likely to be productive. It's necessary to speak clearly so they can understand you and allow them more time to think about questions and respond to them. Finally, it's crucial to maintain a positive attitude during the discussion. It helps to be aware of the anxieties older people often have, such as concerns about their health or mental capabilities. We can uncover alot more with most elderly people, if we let them control parts of the conversation and assure them that they don't need to be afraid.

Linda: Caring for someone who is depressed or suicidal can be frightening, if only because there sometimes seems to be so little we can do to help them. Yet, there is something we can do that will help them. Talking really helps. If you can empathize with someone who feels like their life isn't worth living anymore, and let them know you hear them, that helps their suffering. It lets them know someone cares, and that life is really worth living after all.

Annotated Bibliography of Books and Articles

Archibald, J.W., and Ullman, M.A. (1983). Is it senility - or just depression? *RN, 46,* (11), 49-51.

This article shows how to distinguish between these two conditions and offers ideas on treatment for depression. Includes clues to elderly depression.

Beck, A.T., Resnik, L.P., and Lettieri, D.J., (Ed.). (1974). *The prediction of suicide.* Bowie, MD:Charles Press.

A collection of articles reviewing historical and philosophical perspectives on classification, basic research issues in suicide prevention, and scales used to predict suicide. Numerous means to evaluate suicide risk are provided and evaluated.

Blazer, D.G. (1982). *Depression in late life.* St. Louis: Mosby.

A thoroughly documented book which separates knowledge about depression from speculation. This really helps to clarify a fuzzy issue. It includes an historical view of depression, a description of elderly depression, etiologies and epidemiology of depression, a section on diagnosis of depression, and one on treatment. Case presentations of depressive disorders demonstrate diagnostic and treatment methods. Numerous therapies are reviewed, including psychotherapy, family therapy, ECT, physical, and nutritional therapies.

Blazer, D.G., Bachar, J.R., and Manton, K.G. (1986). Suicide in late life: Review and commentary. *Journal of the American Geriatrics Society, 34,* (7), 519-525.

An article analyzing suicide statistics which focuses on suicide trends in young and elderly populations, cohort suicide rates, and future projections of elderly suicide. Cohort effects are demonstrated and a prediction of higher suicide levels when the "baby boom" cohort reaches old age is made. Possible reasons given for the cohort size effect, include competition in larger cohorts, social stress, delayed marriage, fewer children, frequent divorce, and feelings of alienation. Another possibility is that the increase in size of the elderly population will be beneficial to the elderly since the health care industry will orient itself to serve this population.

Chaisson, M., Beutler, L., Yost, E., and Allender, J. (1984). Treating the depressed elderly. *Journal of Psychosocial Nursing,* 22, (5), 25-30.

An exploratory pilot study in which a group of 12 nurses and mental health professionals received an accelerated ten week, 20 hour training program in cognitive therapy. Eight out of twelve learned the techniques of cognitive therapy and when they counseled elderly subjects, the depression levels of the subjects declined. The article contains a good, brief review of the cognitive theory of depression.

Chaisson-Stewart, G.M., (ed.). (1985). *Depression in the elderly: An interdisciplinary approach.* New York: Wiley.

A very practical compendium covering theory, diagnosis, and treatment of depression. Such interventions as drug treatment, nutrition, exercise, psychotherapy, group therapy, voluntarism, and therapeutic institutional environments are reviewed. This book functions as an advocate for the patient and takes a holistic, multidisciplinary approach to treating depression.

Cunningham, B. (1984). Nursing assessment of depression in the aged adult. *Home Healthcare Nurse,* 2, (4), 9-16.

Reviews a holistic approach to assessment of depression. This article reviews multiple etiologies of depression and summarizes symptoms of organic brain syndrome and pseudementia, which can be confused with depression. It also explores barriers to assessment and defines a nursing role in the assessment of depression.

Fry, P.S. (1986). *Depression, stress, and adaptations in the elderly: Psychological assessment and intervention.* Rockville, MD: Aspen,

This is a detailed, exhaustive text intended for the clinical practitioner. Fry reviews biological, psychological, and social characteristics of aging, and provides a multidimensional approach to assessing the elderly. Special consideration is given to assessing clinical depression, cognitive impairment, stress reactions, and functional disorders such as hypochondriasis and alcohol abuse. Psychotherapeutic approaches for depression and grief include individual psychotherapy, group therapy, family therapy, and integrated therapies. A useful review of psychopharmacology and the elderly includes general guidelines for monitoring side effects of medications. Fry also discusses alternatives to custodial care in the elderly.

Gernsbacher, L.M. (1985). *The suicide syndrome: Origins, manifestations, and alleviation of human self-destructiveness.* New York: Human Sciences.

The "suicide syndrome" is a developmental approach to suicide, which starts in infancy and results in the expression of three adult suicidal types: the antipathic, synpathic, and apathic suicidal personalities. Different motivations and crises are defined for each type, and methodologies for treating them are discussed.

Hatcher, B.J., Durham, J.D., and Richey, M. (1985). Overcoming stroke-related depression. *Journal of Gerontological Nursing, 11,* (11), 35-39.

Reviews stroke and its psychosocial consequences, and presents a case study of a 66 year old stroke patient. Interventions used included cognitive therapy, planned activities, and a 12 hour a day one-to-one intensive nursing care plan. This article provided a good review of one patient's recovery.

Hawranik, P. and Kondratuk, B. (1986). Depression in the elderly. *Canadian Nurse, 82,* (9), 25-29.

A useful article which profiles elderly depression and gives practical suggestions for developing nursing care plans.

Hirst, S.P., Brockington, W., and Sheesley, L. (1985). Suicide among the aged: Concern for care givers. *Dimensions Health Service, 62,* (10), 25-27.

A general article on elderly suicide which includes Canadian statistics, risk factors, assessment, and interventions.

Kirsling, R.A. (1986). Review of suicide among elderly persons. *Psychological Reports, 59,* 359-366.

A review of the literature on suicide which includes discussions of prevalence in the U.S. and other countries. Contributing factors to elderly suicide include depressive complaints, bereavement, retirement, socioeconomic status, and the level of unbearability. Projections and preventive strategies are reviewed, with the recommendation that new and innovative measures be adopted for the elderly.

Maltsberger, J.T. (1986). *Suicide risk: The formulation of clinical judgement.* New York: NYU Press.

Maltsberger's 20 years of experience with suicidal patients are evident in this well-written book. From a psychoanalytic perspective Maltsberger discusses vulnerability to suicide, the suicide crisis, recognizing the suicidal patient, and the formulation of suicide risk. A strong point of this book is the section on pitfalls in estimating suicide danger.

Maris, R.W. (1981). *Pathways to suicide.* Baltimore: Johns Hopkins.

This book provides a unique perspective on suicide. Maris compared data on 300 completed suicides with suicide attempts and natural deaths. He contends that multiple suicide attempters and suicide completers are separate populations and that suicide is the culmination of a suicidal career rather than a response to an immediate crisis. Factors pertinent to these suicidal careers are reviewed in the book, which has much information and is easily readable.

McIntosh, J.L. (1984). Components of the decline in elderly suicide: Suicide among the young-old and old-old by race and sex. *Death Education, 8,* 113-24.

Statistical article on elderly suicide which focuses on decrease in elderly suicide rates from 1933 to 1978. Decreases in rates were shown to be primarily a white male phenomenon, with the largest declines occurring among the young-old (age 65-74). Speculation on causes of decline include antidepressant drugs, suicide prevention centers, social welfare programs, increasing numbers of non-suicidal females reaching old age, and cohort differences.

Moore, I. (1986). Ending it all. *Nursing Times, 7,* 48-49.

A short article which provides information on elderly suicide in England and Wales.

Newman, M.A. and Gaudiano, J.K. (1984). Depression as an explanation for decreased subjective time in the elderly. *Nursing Research,* 33, (3), 137-139.

Sixty eight ambulatory women over 65 years of age were tested using the Beck Depression Inventory. Subjects were also required to respond at intervals of 40 seconds. The hypothesis that depression was related to decreased subjective time was supported (more depressed people responded with longer time intervals than 40 seconds). The authors concluded that if older people can be helped to expand their experience of time, the quality of their life may be improved.

Osgood, N.J. (1985). *Suicide in the elderly: A practitioner's guide to diagnosis and mental health intervention.* Rockville, MD: Aspen.

Osgood's text has major sections on assessing suicidal susceptibility in elderly people and interventions that can be used. She solidly substantiates prevalence of suicide in the elderly and provides a profile of the suicidal elderly through documented case histories. A conceptual model of suicide and review of psychodynamics of suicide is included, as well as a treatment of societal attitudes toward the suicidal elderly. A big plus is that this text contains 16 scales to assess well-being, depression, loneliness, and stress. Interventions include the use of support groups, reminiscence and life review therapy, various creative therapies (such as art and music therapy), and stress management. Melville and Blazer provide a chapter on the etiology and assessment of depression in the elderly, and Borson and Veith contributed a chapter on Pharmacological Interventions.

Osgood, N.J. (1985). Identifying and counseling the suicidal geriatric patient. *Geriatric Medicine Today, 4,* (3), 83-92.

A practical, information-packed article on elderly suicide which discusses factors in elderly suicide, clues to suicide, assessing suicide risk, and counseling strategies.

Osgood, N.J. (1987). The alcohol-suicide connection in late life. *Postgraduate Medicine, 81,* (4), 379-384.

Explores the impact of alcohol abuse on elderly suicide. Includes statistics on the problem, case studies of three alcoholic suicidal elderly people, warning signs, and prevention strategies. This article, which includes a handout on information for patient's families, is very useful.

Palmore, E., Busse, W., Maddox, G., Nowlin, J., and Seigler, I.C. (eds.). (1985). *Normal aging III.* Durham: Duke University.

This is an interdisciplinary compendium of articles dealing with the aging process which has major sections on physical aging, mental health, psychological aging, and social aging. This volume stresses a longitudinal approach to the study of aging. Focus is on normal aging and the problems typically encountered by older people rather than unusual difficulties. Introductions to each section and a summary at the end summarize the main themes and findings of the articles.

Parent, C.J. and Whall, A.L. (1984). Are physical activity, self-esteem, and depression related? *Journal of Gerontological Nursing, 10,* (9), 8-11.

Thirty adults aged 60 and over were tested using the Functional Life Scale (FLS), Self-Esteem Scale, and Beck Depression Inventory. As expected, self esteem and depression were strongly negatively correlated. The only significant correlation with physical activity scores were monthly activity scores and self-esteem scores ($r = -0.4285$, $p < 0.05$). This means that they found more depressed people were less active, and vice versa. In light of the low levels of correlation found, the authors argue that the FLS instrument needs refinement.

Parsons, C.L. (1986). Group reminiscence therapy and levels of depression in the elderly. *Nurse Practitioner, 11,* (3), 68-76.

Differences in levels of depression in six subjects undergoing six sessions of group reminiscence therapy were measured using a pre-test post-test research design. The Geriatric Depression Scale was used to measure depression. An immense decrease in levels of depression was observed. The author speculated that reminiscence could have prompted reevaluation and reorganization of life memories, reminded subjects of positive past experiences, provided an opportunity to help others, and provided social interaction all of which could have alleviated depression.

Reed, P.G. (1986). Developmental resources and depression in the elderly. *Nursing Research, 35,* (6), 368-74.

A cross-lagged correlational study of depression and developmental resources in matched groups of 28 healthy and 28 depressed older adults. Developmental resources are assets which emerge from person-environment interactions. An example would be acquiring a sense of satisfaction about one's body and health. Three courses of testing were done at six week intervals since crisis theory indicates most clients find some resolution of the problem underlying their hospitalization within four to six weeks. Results supported the hypothesis that developmental resources and mental health in later life were associated with each other.

Resnik, H.L.P., (ed.). (1968). *Suicidal behaviors: Diagnosis and management.* Boston: Little, Brown and Co.

A very broad interdisciplinary compilation of articles relating to suicide. Major sections include general considerations, diagnostic considerations, clinical management, and community management.

Riccitelle, G.K.L. (1983). The coming of age of Mrs. H., *Curationis, 6,* (1), 28-30.

A case study of a 70 year-old, physically healthy, married, depressed woman. Includes psychological theories of aging, group and milieu therapy.

Richman, J. (1986). *Family therapy for suicidal people.* New York: Springer.

Since problems in familial or marital/couple relationships are so often seen in suicide, it's surprising few books on suicide approach the problem from a family systems perspective. Sections of the book include origins of the suicidal crisis, family assessment of suicidal potential, and a section on family process and family therapy. This is a highly readable book which could be used by nearly all professional practitioners.

Roth, M. (1986). Differential diagnosis of psychiatric disorders in old age. *Hospital Practice, 21,* (7), 111-138.

An extensive article on psychogeriatric disorders. It is readable but requires an acquaintance with psychopathology. Topics reviewed include prevalence, depression, anxiety disorders, organic syndromes, dementia, clouded and delerious states, depressive pseudodementia, amnesic syndromes, late paraphrenia, mixed psychoses, and the diagnostic process. Elements of a full psychiatric formulation are listed. This article is very specific in its definitions and characterizations of disorders, which permits discrimination in diagnosis.

Shneidman, E.S., (ed.). (1986). *Essays in self-destruction.* New York: Science House.

Perhaps the broadest collection of essays on suicide available. The book is divided into four parts: literary and philosophic essays, sociological and ethnographic essays, psychological and psychiatric essays, and taxonomic and forensic essays. Articles range from "The Passions of Herman Melville" to "Can a Mouse Commit Suicide?"

Shneidman, E.S. (1981). *Suicide thoughts and reflections 1960-1980*. New York: Human Sciences Press.

This book is a collection of ten pieces on suicide which provides a good sampling of Shneidman's writing. One focus of the book is on the psychodynamic approach to suicide; particularly the thinking styles of suicidal people. Other topics include psychological autopsy, suicide notes, and care of suicide survivors.

Stanley, B. (ed.). (1985). *Geriatric psychiatry: Ethical and legal issues*. Washington: American Psychiatric Press.

This short volume addresses legal issues such as family rights in treatment decisions and confidentiality; informed consent and competency in the elderly (including various forms of proxy consent); the role of denial in Alzheimer's disease; ethical issues in geriatric research (with a focus on the need for regulations and the ways that current policies protect participants); and ethical issues in evaluating elderly patients (which pays particular attention to the way in which elderly clients communicate their needs).

Szasz, T. (1986). The case against suicide prevention. *American Psychologist, 41*, (7), 806-812.

A thoughtful article by a leading psychiatrist which explores the question of who really bears responsibility for another's suicide. The author contends that rejecting suicide prevention as a professional responsibility would prevent mental health agencies from being forced into conflicting roles and affirm the principle that people bear responsibility for their own actions.

Tideiksaar, R. (1985). Geriatric suicide. *Physician Assistant, 9*, (11), 78-91.

An excellent, concise article intended for primary care clinicians which reviews a thorough set of risk factors for geriatric suicide and information on the assessment and management of suicidal crises. The article contains "clip and carry" inserts which profile elderly suicides and suggest questions for assessment and means of intervention.

Valanis, B.G., and Yeaworth, R. (1982). Ratings of physical and mental health in the older bereaved. *Research in Nursing and Health, 5*, 137-146.

Sixty widowed individuals were assessed using a modified Older Americans' Resources and Services, Multidimensional Functional Assessment Questionnaire (OARS) and the Zung Self-rating Depression Scale. Researchers were unable to demonstrate a difference between subjective and objective measures of depression. Older women were especially optimistic in self-ratings of health compared with interviewer ratings.

Waller, M. and Griffin, M. (1984). Group therapy for depressed elders. *Geriatric Nursing. 5*, (7), 309-311.

A report on the Special Needs Project for Aurora Seniors which has been in place at the Aurora, Colorado Senior Citizen's Center since 1979. The project's goal was to prevent depression from escalating into crises and suicide attempts. Group therapy was the method of intervention. Common themes included handling stress, coping with frustration, adjusting to retirement, and fighting loneliness. A study of 17 participants using the Hamilton Depression Inventory to assess depression yielded inconclusive results.

Weinstein, W.S., and Khanna, P. (1986). *Depression in the elderly: Conceptual issues and psychotherapeutic intervention*. New York: Philosophical.

Weinstein and Khanna provide a general introduction to the issue of depression in the elderly which includes sections on differential diagnosis that enables variations of depression to be distinguished and on factors associated with late life depression The bulk of the section on psychotherapeutic approaches revolves about traditional and modified analytical approaches, although brief psychotherapy, behavioral, and group therapy approaches are also reviewed. Weinstein and Khanna demonstrate that despite negative stereotypes and prejudicial biases on the part of society and therapists, psychotherapy has been successful in treating depression and other emotional dysfunction in the elderly.

Weiss, J.C. (1984) *Expressive therapy with elders and the disabled: Touching the heart of life*. New York: Haworth.

This practical, well-written text reviews techniques of expressive therapy (including art therapy and writing) with regard to treating regression, improving reality orientation, developing self-awareness and expression, improving communication, and expressing feelings. A section entitled "the experiential process" shows what an art therapy session is like.

Wekstein, L. (1979). *Handbook of suicidology: Principles, problems, and practice*. New York: Bruner/Mazel.

This is a good general text on suicide which is useful as a training resource. It includes the expected historical overview, classifications of suicide, theory, and intervention but goes well beyond that. For example, it includes an analysis of workshop problems from the 1978 American Association of Suicidology Training Manual, and a section on clinical studies. Wekstein writes as a physician, but takes alternate views of suicide seriously. His book should appeal to a diverse audience.

Whall, A.L. (1986). Identifying the characteristics of pseudodementia. *Journal of Gerontological Nursing, 12,* (10), 34-35.

A short article which focuses on the need for practitioners to be able to discriminate between depression and pseudodementia.

Willis, R.H. (1985). The emergencies of old age: Suicide. *Emergency Medicine, 17,* (19), 131-141.

Intended primarily for physicians, this article walks you through an interview to determine whether a patient is suicidal giving pointers on what questions to ask and how to ask them. It also refers to the caregivers' own feelings as indicators of the patient's well-being and as potential blocks to elucidating a patient's condition.

Yeaworth, R.C. and Valanis, B. (1985). Health status and resources of recently bereaved older persons. *Public Health Nursing, 2,* (4), 232-244.

Sixty widowed individuals were compared at three to four and nine to ten months with an age-matched group of nonbereaved using major sections of the Duke University Older Americans' Resources and Services Assessment Questionnaire and the Zung Self-Rating Depression Scale. Greatest impairment of bereaved were in areas of physical health and economic resources. Social and economic resources were highly correlated with physical and mental health for both groups. Only the nonbereaved group showed a correlation between age and physical health or age and depression.

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Please indicate how helpful the parts of this module were to you by marking an x on the scale below each item.

2. *Training Manual*

Helpful	1	2	3	4	5	6	7	8	9	Not Helpful
Irrelevant	1	2	3	4	5	6	7	8	9	Pertinent
Too Simple	1	2	3	4	5	6	7	8	9	Too Complex
					Ideal					
Easy to Use	1	2	3	4	5	6	7	8	9	Hard to Use
					Ideal					

Comments on Training Manual:

3. *Training Effectiveness:*

Ineffective	1	2	3	4	5	6	7	8	9	Effective
Suicide not seen as threat	1	2	3	4	5	6	7	8	9	Suicide seen as possible
Staff feels Prepared	1	2	3	4	5	6	7	8	9	Staff feels Unprepared
Policies Not Likely	1	2	3	4	5	6	7	8	9	Policy exists or beingdeveloped

Overall Comments:

Feedback Instrument

Only you can tell us whether this educational module has met your needs, and how we can better serve you in the future. Please help by answering these questions and returning this form to:

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1. *Videotape presentation*

Not helpful ..... Very Helpful
1 2 3 4 5 6 7 8 9

Boring ..... Interesting
1 2 3 4 5 6 7 8 9

I can not ..... It could have
Believe it 1 2 3 4 5 6 7 8 9 Happened

Too Short ..... Too Long
1 2 3 4 5 6 7 8 9
Ideal

Too Simple ..... Too Complex
1 2 3 4 5 6 7 8 9
Ideal

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